LANHAM, MD

2. Date of Death

	Physic /Medi		ANTHONY	WILSON	June 2 2007 6 am M						
	Exami	ner	4a. Facility Name (If not institution, gi	· ·		•	r Location of Death			ty of Death	DCE!C
			DOCTOR'S HOS			LANHA If Under 1 Year			PRIN		
	Funeral Director			Sex 1 2 F 7. Age (In yrs. 1 50	Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan 20 1	Year) L <b>957</b>	Couin	lace (State or Foreign try) <b>LNGTON , DC</b>
	pur *	1	Usual Residence of Decedent  10a. State 10b. County	10c Cit	y, Town or Lo	nation				-	Od Inside Oits Limite
	shor shor	5								110	0d. Inside City Limits 1 XYes 2 □ No
	he N	Director	MD PRINCE  10e. Street and Number	GEORGE'S	LAND	1			0.00		
	after death with the Maryland or items 23a or 28a-f show miner must be notifiled at	ä		DITTE		10f. Zip Code	10 E	10	-	f What Coun	try?
5	eath	Funeral	8108 ALLENDALE I		C 142 V	207				ace - America	an Indian
-2	ter d	Fun	11. Marital Status  1	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 No	.s. 13. ¥	f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerlo	Rican, etc.)	ВІ	lack, White, e	etc.
$\sim$ $^{\rm g}$	al',o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	☐ Yes <b>X</b> ☐ No	Specify:		Spec	city: BLAC	CK
7.000/	72 hours after death with the Marylar "natural", or items 23a or 28a-f show idical Examiner must be notified at	Completed	15. Decedent's 8	Education	16a. Deced	lent's Usual Occup	ation	1	6b. Kind of	Business/Ind	dustry
218	within 72 ene. than "nal	Jple	(Specify only highest g. Elementary/Secondary (0-12)	College (1-4or 5+)	life. E	kind of work done i OO NOT use retired	during most of word d)	king			
- N	filed wi Hygien other th	Sol		2	AS	SISTANT M	IANAGER		P	RIVATI	Ε
H / )	be filed within 72 ho ttal Hygiene. d other than "natu event, the Medical	Be	17. Father's Name (First, Middle, Las	•				ne (First, Middle, M		ame)	
A () ryland	ould be f Mental I narked of natic eve	2	COSTELLO P. WII					E MAE BAN			
ĭa, ∠	ges 1 and 2 should t of Health and Men if Item 27 is marke or other traumatic		19a. Informant's Name/Relationship COSTELLO P. WII					ral Route Number, WASHING			
ore, I	ges 1 t of He if item or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [		lace of Disposemetery, cren	sition (Name of natory or other place	ce)	Date 2	Oc. Location	n - City or To	wn, State
Z Ĕ	mit. Pages partment of I cortant: If its Injury or o		4 □ Donation 5 □ Other (Spec	2007 R	RIVERDALE, MARYLAND						
W       5 0   Baltimore,	permit. Depart Import any inj		21. Signature of Funeral Service Lice	ensee	22	. Name and Addres	ss of Facility J.	B. JENK			
	0 - € 0		3	<b>.</b>				LANDOVE		TLAND	20785
o o	Physician /Medical Examiner physician and ph	Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence.  Due to (or as a consequence.	uence of):	rene e hed	al d	e		Approximate Interval Between Onset and Death	
P.O. Box 68760,	he death certificate the attending physiched for use as the l	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	I death 3□ eath 5□	Ectopic pregnancy Other (specify)			23d. Date of delivery  Month Day Year		
	requires that t een signed by nould be detac	by	Part II. Other significant conditions			derlying cause give	en in Part I.	23e. Did toba	acco use co	ntribute to th	e cause of death?
ord	equir sen si ould I	pel	Wraket	u meli	114	ς		1 □ Yes	2 🛐 No	3 ☐ Prob	ably 4 □Unknown
Division or Vital Records,	Physician: The law r this certificate has be al director, page 2 sh	Completed				. <u>.</u>		24a. Was an autopsy perform 1∏ Yes 2		prior to con death?	psy findings available npletion of cause of
ta	ian: rtifica ctor, p	Be C	25. Was case referred to medical				26. Place of Dea	th (Check only one		T Hes	211 NO
>	nysic nis ce direc	10	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient	3 DOA Othe	er: 4 \sum Nursing He	ome 5 ☐ Resider	nce 6 🗆 O	ther (Specity	()
ion o	ending Plath. In: After the		27. Manner of Death  11. Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Work		28d. Describe hov			
Divis	e Hospital or Attend 24 hours after death Funeral Director: / etely filled in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not to determined		me, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	eet and Nun State)	mber or Rurai	I Route Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	hysician: To the best of my know miner: On the basis of examinat and manner stated.	wledge, death tion and/or inv	occurred at the ting restigation, in my o	me, date and place pinion, death occu	, and due to the car rred at the time, da	use(s) and rate and place	manner as st e, and due to	ated. the cause(s)
	To the vithin To the comple	M	29b. Signature and title of certifier	1 MD		29c. License	e number 58446		d. Date sign	ged (Month, L	Day, Year)
	(1)	-	V/ 7	11.10					-/(	,,,,,,	/

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 0 7 2007

81186000 LUCK RUAD

of death (Item 23a) (Type, Print)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		- For State Registrar		Certific	ate of	Death			Reg	, No.	E		
Physicia	n/	<ol> <li>Decedent's Name (First, Middle,La</li> </ol>							ate of Death	Day	Year		Time of Death
Medical Examin		Daragh Demetrius						J۱	ine 1, 200	)7			0340 hrs
		4a. Facility Name (if not institution, gi Prince Georges Hospital			4k	Cheverly	ocation of E	Death			unty of De Ce Geor		
Funeral	7	5. Social Security Number 6. S	Sex 7. Age	e (In yrs. last bir	thday)	If Under 1 Year	If Under 2	24Hrs. 8.	Date of Birth	(MM/DD/Y			ace (State or
Director			M 2 F	32	Yrs.	Months Days	Hours	Min. At	ıgust	29,19	74	reign Countr	y) DC
any	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Locatio	n						10	d. Inside City Limits
<b>≱</b> .:	۲	DC		Washin								1	X Yes 2 No
laryla 28a-f	Director	10e. Street and Number				10f. Zip Code		_	10	g. Citizen o	of What C	Country'	?
the Na or Stiffed	<u>=</u>	1842 Capitol Av	e. NE		i	20002	)			U.S.A	Δ		
with ns 23	ļa Ta	11. Marital Status	12. Was Decedent	Ever in U.S.		Decedent of Hisp	anic Origin		Yes or No-	14.1	Race - An		Indian, Black,
5-0036 led within 72 hours after death with the Maryland tygiene other than "naturat", or items 23a or 28a-f sho the Medical Examiner must be notified at once.	Funeral	Never Married 2 X Marrie  Widowed 4 Divorce	1 X Yes 2			s, specify Cuban, Yes $2X$ No		uerto Rica	in, etc.)	Spe	White, etc	Bla	ck
rs after uraf"	ᇍ	15. Decedent's Education (Specify	or Dates:	7-98		s Usual Occupation		d of work	done	16b. Kind			
2 hou "nat	ğ	Elementary/Secondary (0-12)	College (1-4 or 5	<u> </u>		st of working life.							
36 thin 7 than than edica	힑		1	T	ruck	Driver				Reta	ail		
5-0036 iled within 72 Hygiene I other than '	Completed by	17. Father's Name (First, Middle, Las	t)	1		1	8.Mother's I	Name (Fir	st, Middle, M	aiden Surr	name)		
21215-0036 Muld be filed within 7 Mental Hygiene marked other than	Be	Frederick Green					Susan	War	d				liles
21 hould nd Mei is man		19a. Informant's Name/Relationship (			_	Address (Street							
e, MD  I and 2 sho Health and item 27 is		Susan Ward-Chas	e/Mother_			apitol A							
ages 1 and 2 shount of Health and Nt. If item 27 is nother traumatic		20a. Method of Disposition  1 X Burial 2 Cremation 3	Removal from Sta	ate crema	tory or other			Da		20c. Loca	tion - City	yorio	wn, State
Page Page nent cant:		4 Donation 5 Other Specifi		Ft. I		Ln Cemet	-			Brent		, M	D
Baltimore, permit Pages I an Department of Hea Important: If itei	ſ	21. Signature of Funeral Service Lice	ensee			me and Address						_ ^	0700
	_	Keehal Thon -4				)1 Blade:						_	
Physician /Medical		23a. Part I. Enter the disease, or com failure. List only one cause on e	each line.		ot enter the	e mode of dying, s	such as card	diac or res	piratory arre	St, Shock, (	or neart		Approximate Interval Between Onset and
xaminer	Ì	Immediate Cause (Final disease or condition resulting in death)	Stab Wound of	_								-	Death
X.,			Due to (or as a conse	equence or).									
	盲	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	equence of):									
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a conse	equence of):									
ecuted and transit		events resulting in death) Last	i										
an exe	/Medical	UNPENDED	AMENDED										
760, ficate be ext g physician the burial -	§	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome	ne of pregnancy							ate of deli		
cath certif	ä	past 12 months?	1 Live birth 4 Pregnant at				Ectopic p	regnancy		Mor	nth	Day	Year
Box 68's e death certificate the attending cd for use as 1	Physician	1 Yes 2 No 9 Unknow			o Otn	er (Specify)				Î			
O. Bo at the de 1 by the tached f		Part II. Other significant conditions	contributing to death	n but not resulting	ng in the ur	derlying cause gi	iven in Part	1.					cause of death?
ires that the signed by the detache	Completed by								1 Yes	2 🗸 No	3	Probab	ly 4 Unknown
of Vital Records, ng Physician: The law requir Nher this certificate has been si nneral director, page 2 should t	활							115	24a. Was a				sy findings available pletion of cause of
e law	틹							_	perform 1 ✓ Yes 2	med?	deat		2 No
I R		25. Was case referred to medical				26.Place	of Death (C	heck only					
Vita ysicia his ce direct	10 Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	ent 2 🗸 ER/0	Outpatient	3 DOA	Other 1	Nursing H	ome 5 1	Residence	6C	Other:	
of " "g Ph After t		27. Manner of Death	28a. Date of Inju		Time of In	jury 28c. Injur	y at Work?		i. Describe h bject stab		occurred		
Division at or Attendi rs after death. at Director: A	Certification:	Natural 5 Pending Accident Investiga	Jun 1, 2007	025	54 hrs	1Y	es 2 ✔ N	10	oject stab	DCu			
ivis or At after d Direc	<u>:</u>	3 Suicide 6 Could no	t be 28e. Place of In	jury - At home,	farm, street	, factory, office be	uilding, etc.	28f	Location (S or Town, St		Number o	r Rural	Route Number, City
Spital Spital	हैं।	4 V Homicide determin	ed (Specify) Mu	Iti-Family A	ot.			155			NE Apt	t. 12, V	Washington, DC
	Medical	29a. Certifier 1 Certifying Physicone) 2 Medical Examin	cian: To the best of mer:On the basis of exam	y knowledge, de mination and/or	eath occurr investigation	ed at the time, da on, in my opinion,	ite and place , death occu	e, and due irred at the	to the cause time, date a	e(s) and m and place,	anner as and due	stated. to the c	ause(s)
To COT	ĕŀ	29b. Signature and title of certifier	and manner stated.			29c. License	e number			29d. Date	signed	(Month	, Day, Year)
		Mill hand	1 Mix			O.C.N	M.E.			June 1	, 2007		
(5)	}	30. Name and address of person who	completed cause of d	leath (Item 23a)									
RU	O:	Melissa Brassell, MD	Assistant Medical	l Examiner	111 P	enn Street, B	altimore,	MD 21	201				
Sta Regista		31. Date filed (Month, Day, Year)	32. Registra	r's Signatus.	V								
	_		A STATE OF THE STA										

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**OCME** 

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) June 4, 2007 Year **Physician** Virginia Tilch Corby Ward 8:40P /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George S Ft. Washington Hospital Ft. Washington If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 15,1926 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2X □ F 80 Yrs Maryland 579-26-5366 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County promitte natified at Fort Washington 1 ☐ Yes 2X No Maryland Prince George's Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 USA 20744 10710 Livingston Road or Items 23a Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Pages 1 and 2 should be filed within 72 hours afte nent of Hazlit and Mental Hygiene.
shirt if tem 21 is marked other than "neturel", or II ury or other traumatic event, the Madical Examirury or other traumatic event, the Madical Examirus or other traumatic event. Specify: White Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) St. Elizabeth's Hospital Assistant Payroll Officer 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Edith Florence Gates Tilch , Sr. Bernard ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7295 Bensville Rd., Waldorf, MD 20603 Nancy Moore-Sister Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Arlington National Cemetery June 19,2007 Department of h Importent: If ite any injury or of spice. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington, Virginia 4 □ Donation 5 □ Other (Specify) permit. 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 21. Signature of Funeral Service License 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner MPHYSEM Sequentially list conditions, if any, leading to immediate caus. Er to underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 No he 9□ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an RIPL autopsy performed page 2 2 No 1 TYes 2 3-No certificate 1 🗌 Yes Division of Vital To the Hospitel or Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 3□ DOA ٩ 2 ☐ EB/Outpatient After thi 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Mannerol Death 28b. Time of Injury at Work? Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident in by the f within 24 hours after death

To the Funerel Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Momicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific MY SICIAN D53782 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE # 101 LIVINGSTON ROAD, 11701 SURESH VERGHETE 82. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 0 7 2007 Registrar

20852

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician /Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

Directo

Funeral

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Be Completed

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**Funeral** 

Director

cate has been signed by page 2 should be detac within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

	Sequentially list conditions. b.		monia									
al Examiner	Sequentially list conditions, if the conditions is cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to or as a consequence of):  C										
ıysician/Medic	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	3c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	al death 3 ☐ Ectopic			23d. Date of del Month	ivery Day Year					
Completed by Physician/Medical	Part II. Other significant conditions conditions  dementia  HTW  depression	1 1 1	ulting in the underlying wipley STOH 6	cause given in Part I.  CHO hypercal	1 ☐ Yes  4a. Was an autopsy performe	24b. Were au prior to death?	o the cause of death robably 4 Unkr utopsy findings avai completion of cause					
o Be (	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3		ath <i>(Check only one)</i> Home 5 ☐ Residend	e 6 ∏Other (Spe	cify)					
Certification: T	27. Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how	injury occurred						
Certific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At he building, etc. (Specification)	ome, farm, street, fact fy)	ory, office	28f. Location (Stree City or Town, S	et and Number or R State)	ural Route Number,					
edical (		lician: To the best of my knowner: On the basis of examination and manner stated.										
×	29b. Signature and itle of certifier	ul H	D	9c. License number <b>362</b>	29d	Date signed (Mont	th, Day, Year)					

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Irina Selya, M.D.

JUN 0 8 2007

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar 2101 Jefferson St., Rockville, MD

Type or Print in Black Indelible Ink.	. Ensure All Copies Are Legi
State of Maryland / Department of F	Health and Mental Hygiene

			For State Registrar		State of	Marylan	_	artment of H r <i>tificate of L</i>		d Mental Hy	giene Reg. No.	007	20005			
*	Physici		1. Decedent's Name (First	t, Middle, Last) inia Anr	n Warren					2. Date of D Month May	Day	Year 2007	3. Time of Death 6:50 pM			
	/Medio		4a. Facility Name (If not in					4b. City, Town, or	Location of De			unty of Death				
		- 4	Ca	sey House	2			Rock	ville			Montgome	ery			
	Funeral Director		5. Social Security Number <b>299-32-8951</b>		7. M 2 <b>X</b> F	. Age (In yrs. i	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	lin. 8. Date of Bi (Month, D March 6,	ay, Year)	9. Birthpl Coun	lace (State or Foreign try) Ohio			
	and w		Usual Residence of Deced	dent County		10c City	, Town or Lo	cation				14	Od Incido City Limita			
	Maryla f sho	o				100.00	,, 104110, 20					"	0d. Inside City Limits 1 ☐ Yes 2 🖾 No			
	the h	rect	Maryland M  10e. Street and Number	ontgomery	<i>'</i>			Silver S	brrug		10g. Citizer	tru?				
	3a or	Ď	9916 Ch	erry Tree	e Lane			101. 2.10 0000	20901		rog. Onizor	U.S.A.	шу.			
9	ges 1 and 2 should be filad within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Funeral Director	11. Marital Status 1 Never Married 2	1	12. Was Deced Armed Forc 1  Yes 2 If Yes, Give	<b>★</b> No		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 2 No	spanic Origin? n, Mexican, Pu	(Specify Yes or Nuerto Rican, etc.)		Race - American Indian,     Black, White, etc.				
21215-0036	ours ural;	d by	3 🗷 Widowed 4 🗆 D	livorced	Year or Date	es:		TLI Yes ZENO	Specify:		Sp	ecify:	White			
5-(	"natu	lete	15. D (Specify onl)	ecedent's Educ y highest grade	cation completed)		16a. Deced (Give	dent's Usual Occupa kind of work done d DO NOT use retired,	ation Juring most of t	working	16b. Kind	of Business/Ind	lustry			
12	2 should be filad withir and Mental Hygiene. Is marked other than aumatic event, the Me	Completed	Elementary/Secondary	(0-12)	College (1-4	lor 5+)		istered Nur			Gover	nment Hos	enital			
	filad Hygiv Sther ent, ti		17. Father's Name (First, i	Middle, Last)			8	1000000	e, Maiden Su		<u> </u>					
Maryland	lid be lental rked o	To Be	Jesse Har	old Straw	ı				eila Hague		,					
ary	should and Men s marke umatic	_	19a. Informant's Name/Re	elationship (Typ	oe. Print)		19b. Mailir	ng Address (Street a	and Number or	Rural Route Numl	per, City or T	own, State, Zip	Code)			
	and 2 talth a 27 is		David L. St	raw - Bro	other		9916	Cherry Tree	Lane, S	ilver Sprin	ıg, Mary	1and 2090	01			
ore	of Ha of Ha f Item r oth		20a. Method of Disposition		amayal from St		lace of Dispo emetery, crer	sition (Name of matory or other place	e)	Date	20c. Locat	ion - City or To	wn, State			
Ĕ	Pag ment ant: I ury o		4 □ Donation 5 □ C		emovar from St		t Lincol	in Crematory	Brent	wood, Mar	yland					
Baltimore,	permit. Pages 1 and 2 Department of Haaith a Important: If Item 27 Is any Injury or other tra		21. Signature of Juneral S	The License	hym	OFSP	H	2. Name and Addres ines-Rinald 1800 New Ha	i Funera	1 Home, Inc Avenue, Sil	ver Spr	ing, Mar	yland 20904			
	W. E. S.		23a. Part1. Enter the dise	ease, or complic	chiens that cau	sed the death	. Do not ent	er the mode of dying	g, such as card	diac or respiratory	arrest,		Approximate Interval Between			
8	Physician		Immediate Cause (Final disease or condition a. Malignant Neoplasm of Ovary especially death)													
12.	/Medical Examiner		resulting in death)  a. PATIGNATE NEODIASM OF OVALY  Due to (or as a consequence of):													
	Examiner	_	Sequentially list conditions	s, b												
-	ted isit	nine	if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events	ite -	Due to (or	as a consequ	ience of):									
ь	tificata be executed ig physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	c.	Due to (or	as a consequ	lence of):									
68760,	a be e siciar burià	alE					ŕ									
89	ificata g phy as the	edical		a.												
.O. Box	ne death cer the attandir hed for use	Physician/M	IF FEMALE: 23b. Was decedent pregn in the past 12 month 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	iaiii j		h 2 □ Fetal nt at time of de	death 3	Ectopic pregnancy Other (specify)			23d	. Date of delive Month	ry Day Year			
σ,	uires that the signed by do be detact		Part II. Other significant	conditions con	tributing to dea	th but not resu	ılting in the ur	nderlying cause give	n in Part I.	23e. Did	tobacco use	contribute to th	e cause of death?			
Records,	quires en sigi uld be	ed by							<u> </u>	_ 10	Yes 2 🛣 i	No 3□ Prob	ably 4 □Unknown			
O O	> 0 70	Completed								24a. Was	an 2	24b. Were autop	osy findings available inpletion of cause of			
Ä	<u>ө</u> <u>с</u> <u>ө</u>	шо									ormed? 2. ■ No	death?	npletion of cause of 2□ No			
Vital	slcian: Th certificate rector, pag	Be C	25. Was case referred to	medical					26. Place of [	1☐ Yes Death (Check only		1 165	2 10			
or V	di s	10 E	examiner? 1 ☐ Yes 2 🕱 No	H	ospital: 1 🔼 Inp	atient 2 🗆	ER/Outpatien	t 3 DOA Othe	r: 4 Nursin	g Home 5 ☐ Res	idence 6 [	Other (Specify	()			
n o	ding Ph h. After th funeral		27. Manner of Death 1 X Natural 5 □	Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe	how injury o	ccurred				
Division	Attanding r death. ector: After by the funer	Certification:	2 Accident	investigation Could not be					res 2□No							
Σ	l or Attano after death Director: I in by the	rtifi	4 Homicide	determined	28e. Place of building	f injury - At ho <sub>I</sub> , etc. <i>(Specif</i> )	me, farm, stre ')	eet, factory, office		28f. Location ( City or To	'Street and ∖ wn, State)	lumber or Rura	l Route Number,			
	Hospital 4 hours a Funeral I tely filled		29a. Certifier 1 🕱 C	ortifulna Dhua	iniam. To the h	act of my line	uladas daniti	a conversed at the time					307			
	To the Hospital or Attan within 24 hours after death to the Funeral Director: completely filled in by the	Medical	(Check off) 2 M	ledical Examin	ner: On the bas and manne	is of examinat	tion and/or in	n occurred at the tim vestigation, in my op	oinion, death o	ace, and due to the eccurred at the time	, date and pl	ace, and due to	the cause(s)			
	S S S	2	29b. Signature and title of	certifier	1.6	1.		29c. License				igned (Month, I				
	S		15 news	re UM	Clas	831	MIJ		4615		June	4, 2007				
			30. Name and address of						100 5	1_212 - 27		20050				
	Sta	to	Genevieve W		486				TOO, KOC	ckviile, Ma	ryland 2	UCSU				
	Registr	11		0 5 200	7	pistrar's Signa	2 /	MARS								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deatl Day Month Year **Physician JEANNETTE** JUNE 3, WORTH 2007 4:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 15101 INTERLACHEN DRIVE #1005 SILVER SPRING MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 05/08/1915 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MARYLAND **Funeral** 1 □ M 2 🔼 F 92 Director 217-42-3921 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits Show must be notified at 14 Yes 2 No Director SILVER SPRING or 28a-f MARYLAND MONTGOMERY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 23a 15101 INTERLACHEN DRIVE #1005 20906 U.S.A. items ? . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 점 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 0. WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 Nidowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien. Important: if item 27 is marked other tha any Injury or other traumatic event, then once. CONTRACTING 12 SECRETARY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be IDA GLAZER JOSEPH BLOCK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1113 CARSON STREET, SILVER SPRING, MARYLAND 20901 BRIAN WORTH, SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State MOUNT LEBANON CEMTRY 06/06/2007 4 ☐ Donation 5 ☐ Other (Specify) ADELPHI, MARYLAND 21. Signature of Funeral Service Licensee DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part. Either the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARCINOMA OF BREAST 10 YEARS /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter ordering Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 3 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No DIABETES MELLITUS TYPE 2 24a. Was an autopsy performed? Yes 21X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5% Residence 6 Other (Specify) Hospital: 1⊠Yes 2□ No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 🖾 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Att within 24 hours after do To the Funeral Direct 4 Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only

State Registrar 31. Date filed (Month, Day, Year) JUN 05 200

GEORGE F.

29b. Signature and title of certifier



and manner stated.

30. Name and eddress of person who completed cause of reath (Item 23a) (Type, Print)

29c. License number

D12121

29d. Date signed (Month, Day, Year)

JUNE 4, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** рм Kathryn Loveless Wells 7:59 June 3, 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Montgomery Holy Cross Hospital 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** Months 1□M 2🙀F Aug. 18, 1920 Washington, DC Director 579-18-5120 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" -- "any linury or other traumatic events. 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20902 2427 Eccleston Street Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No SpecifWhite δ 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edith Schladt Harry R. Loveless ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2427 Eccleston Street, Silver Spring, MD 20902 Michael R. Wells/ 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition June 1 ☐ Burial 2 【Cremation 3 □Removal from State Metropolitan Crematory 2007 4 □Donation 5 □ Other (Specify) Alexandria, Virginia 22 Name and Address of Facility ins Funeral Home Inc. 21. Signatu of Funeral Service Licenses MD 20901 Mohen 500 University Blvd, W, Silver Spring, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only only cluse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Septicemia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and use as the burial-tran Due to (or as a consequence of): nding physician Division or Vital Records, P.O. Box 68760, Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy atter Month Day Year in the past 12 months? 1 ☐ Yes 215 No 4□Pregnant at time of death 5 Other (specify) signed by the sold be detached to 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Nunknown Pneumonia, Urinary Tract Infection been ( 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 21 No After this certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: tx Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ⊟Yes 2√∑ No Certification: To funeral 28a. Date of Injury (Month, Day Year) 28d Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death the 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide filled in by 4 Homicide within 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier June 4, 2007 D52261

10

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State

Registrar

Hugo Circle, Silver Spring, MD 20906

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Alan R. Segal, M.D.

0 5

31. Date filed (Month, Day, Year)

JUN

1517

32. Rigistraf's Signature

			State of Maryland	/ Depa	artment o	of Health	and Me	ntal Hyg	iene	7 2000		
	Physici	an	Registrar  1. Decedent's Name (First, Middle, Last)  Denise M. Wilson	Cei	uncate	of Deati	2.	Date of Deat Month	Day Ye	3. Time of Death 8:56 P. M		
4	/Medic Examir	cal	4a. Facility Name (If not institution, give street and number) 1716 Cinnamon Teal. Way		4b. City, To	wn, or Location per Marl	of Death	lay 29, 2	4c. County of the Prince G	Death		
	Funeral Director		5. Social Security Number 21.3–78–9568	st birthday) Yrs.	If Under 1			Date of Birth (Month, Day, eptember	9. 23, 1958	Birthplace (State or Foreign Country) Pennsylvania		
	aryland show	٦c	Usual Residence of Decedent  10a. State 10b. County 10c. City,  Louisiana Concordia Parish	Town or Lo Ferri						10d. Inside City Limits 1 ☐ Yes 2 ☐ No		
	with the M la or 28a-f Lbs notifie	Funeral Director	10e. Street and Number P.O. Box 1616 193 Sunflower Lane		10f, Zip Co	ode 34-0000		1	0g. Citizen of Wha			
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 ie marked other than "natural; or items 23a or 28a-f show mith injury or other treumatic event, the Modical Examinational Examinational and ODGE.	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	1		nt of Hispanic C Cuban, Mexic		y Yes or No- can, etc.)	14. Race - /	American Indian, White, etc. Black		
Maryland 21215-0036	d within 72 ho giene. ir than "naturi i'ie Medical i	Be Completed	Elementary/Secondary (U-12)   College (1-4or 5+)		dent's Usual C kind of work of DO NOT use	Occupation done during moretired)	ost of working	rking 16b. Kind of Business/Industry Concordia Parish Sch Board				
land	uld be filed Aental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last)  Lawrence Gardner	18. Mot		First, Middle, M an Newma	Maiden Sumame) N					
	alth and N		19a. Informant's Name/Relationship (Type, Print) Mr. Kelly L. Wilson, Sr. (Husband)						, City or Town, Sta riday, Lou	te, <i>Zip Code)</i> İsi <i>a</i> na 71334-0000		
Baltimore,	Pages 1 a ment of Her ent: If Item ury or othe				sition (Name natory or othe portal Pa	of er place) ark	2007	20c. Location - Cit Landover, 1	Maryl <i>a</i> nd			
Balt	permit. Departimport any inj		21. Signature of Funeral Service Licensee			Place, I			D.C. 200	,		
	Pnysician /Medical Examiner		23a. Fort1. Enter the disease, or complications that caused the death. Induction of the control	ance of):	er the mode o	of dying, such a	as cardiac or r	espiratory arre	est,	Approximate Interval Between Onset and Death Montths		
8760,	icate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse Classe of High that initiated events resulting in death) Last  b. Due to (or as a conseque c. Due to (or as a conseque d.									
.O. Box 68	Attending Physicien: The law requires that the death certifica relath. relath. sctor: Atter this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as it by the funeral director.	by Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ☒No  9 □ Unknown  23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal d  4 □ Pregnant at time of dea		23d. Date of delivery  Month Day Ye							
۵.	quires that n signed b uld be deta		Part II. Other significant conditions contributing to death but not result	ing in the u	nderlying cau	se given in Par	t I.			te to the cause of death?  Probably 4 X Unknown		
Division of Vital Records,	nyeicien: The law requir nis certificate has been si I director, page 2 should I	Completed						24a. Was a autops perform	y prio. ned? dea	e autopsy findings available r to completion of cause of th? Yes 2⊠ No		
of Vita	Physicien this certifi al director	To Be	25. Was case referred to medical examiner?  1 Yes XXNo Hospital: 1 Inpatient 2 El	P/Outpatier	nt 3□ DOA			Check only on 5 ☐ Reside		Mother's Specimes 1 de 100		
rision c	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	Month, Day Year)  2 Accident investigation  3 Suicide 6 Could not be determined 28e. Place of Injury - At hom	8b. Time of Injury	М	. Injury at Work? 1 ☐ Yes 2 [	□No	f. Location (St		or Rural Route Number,		
ā	ospitel or hours afte unerel Dire ly filled in b		4 Homicide building, etc. (Specify)  29a. Certifier	edge, deat	h occurred at	the time, date	and place, and	City or Town		er as stated.		
	To the Hospitel within 24 hours a To the Funeral Completely filled	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and mamer stated.  29b. Signature and title of certifier	n and/or in		my opinion, d		2	9d. Date signed (A	fonth, Day, Year)		
	- S - S			220) /T		19432			June 4, 200	)/		
12	(8)		30. Name and address of person who completed cause of death (Item 2  Frank M. Ryan, M.D. 11701 Livingston R	oad, #	103 Fort	Washing	ton, Mar	yland 2	20744			
	Sta Registi		31. Date filed (Month, Day Year)  JUN 0 6 2007  Sacrat 32. Registrar's Signatu	Z.d	•							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Weitzell Jun 15, 2007 3:20am <sup>M</sup> Magdellan /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Allegany Beverly Living Center of Cumberland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar 6, 1923 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗐 F Й'n 216-22-7352 84 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at Allegany MD Cumberland 1 ¥Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14604 Brant Road, SW 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xio Specify: þ Specify: 3 X Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home d 2 should be filed w h and Mental Hygier 7 Is marked other tt or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked o any Injury or other transmits. Milner Frankenberry Hannora Dickel Frankenberry ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD 21502 15000 Creek Point Road Cumberland Vicki Durr daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Restlawn Memorial Gardens 6/18/2007 MD LaVale 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Fart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the origing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transit Division or Vital Records, P.O. Box 687605 and Due to (or as a consequence of) attending physician Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐ Yes 2☐ No the 9□Unknown 9 ☐ Unknown ģ been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2□ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy performed? res 28 No (0 certificate Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

3

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who



pleted cause of death (Item 23a) (Type, Print)

and manner stated

29c. License number

Examiner certificate be executed as the burial-tran Box 68760. attending physician nse P.O. the signed by Division or Vital Records, neral Director: A filled in by the fu death 20 To the Hospital within 24 hours a To the Funeral C

show r 28a-f sh notified

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item 27 is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must to

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permi. Pages Deparment of Impor ant: If it any Ir jury or o ment of

ME: WENCE JOHN Baltimore, Maryland 21215-0036

	d.				· · · · · · · · · · · · · · · · · · ·	
FEMALE: b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23	3c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3 ☐ Ectopic	pregnancy (specify)		23d. Date of delivery Month Day Year
t II. Other significant condit	lons con	tributing to death but not resu	ulting in the underlying	g cause given in Part I.	23e. Did tobacco	use contribute to the cause of death
ADVAN	CED	DEMENTIA	<b>†</b>		1 ☐ Yes	2 No 3 Probably <b>4</b> Unkr
					24a. Was an autopsy performed?	
Was case referred to medica				26. Place of D	eath (Check only one)	
1 Yes 2 No	H	lospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 Residence	6 ☐Other (Specify)
Z [] / tooldelit	ng igation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28d. Describe how inj	ury occurred	
3 Suicide 6 Could 4 Homicide determ		28e. Place of injury - At he building, etc. (Specif	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)		

JH-8

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

046561

诸 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month. Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GHAZALA QADIR, 20311 LAPPANS ROAD, BOONSBORO, MARYLAND 21713 301-432-8470

31. Date filed (Month, Day, Year) JUN 0 6 2007

32. Régistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 4 2007 11:59 A M 6 William H. Wells /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Ocean City Worcester 109 Talbot St. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1X M 2 ☐ F Director 212-40-4055 64 7/14/1942 MD Usual Residence of Decedent t. Pages 1 and 2 should be filed within 72 hours after death with the Maryland riment of Health and Mental Hygiene.

Tant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No MD Worcester Ocean City 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 21842 109 Talbot St. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1X Never Married 2 Married ☐ Yes 2▼ No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify <u>Ş</u> Specify: White 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Night Auditor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tra Wells 2 unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Richie/Friend 109 Talbot St., Ocean City, MD 21842 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 5 Hanover. 07 4 Donation 5 ☐ Other (Specify) 21. Signature of Faneral Service Lic 22. Name and Ad ress of acility The Burbage Funeral Home 108 William St., Berlin, MD 21811 Fart1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Failure Physician Respiratory resulting in death) /Medical Due to (or as a consequence of): Examiner COPD Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform 25. Was case referred to medical Be 26. Place of Death (Check only on examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 21 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To funeral 27. Manner of Death 28a. Date of Injury 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural

Division or Vital Records, P.O. Box 68760. or Attending Physician; after death

5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

(Check only one) and manner stated. 29b. Signature and the

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29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jason

D005870 Philadelphia AW

BAZ State Registrar

31. Date filed (Month, Day, JUN 0 6 2007

mo 32. Registrar's Signature

1001 double

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Andrew Erchi Yu p M June 3, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4711 Berwyn House Road, #521 College Park Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F Yrs. Director 090-64-7906 85 June 9, 1921 China Usual Residence of Decedent 10a. State 10c, City, Town or Location 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notifled at 1 ☐ Yes 2 → No Director Maryland| Prince George's College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examination 2006. 4711 Berwyn House Road, #521 20740 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 No ò Specify SpecifAsian 3 ₩idowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chemical Engineer Government. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Yu Unknown Yia ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Genevieve Yu/Daughter 2316 Casa Bona Avenue, Belmont, CA 94002 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition June Date 7, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2007 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd, W, Silver Spring, 21. Signature of Funeral Service Licensee J. Ken Skile MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Myelodysplastic Syndrome **Physician** 4 Years disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? ∕es 2☐No 2□ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 3 Residence 6 Other (Specify) 1☐ Yes 2☐ No 1 Inpatient ို 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Natural s after deau... 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a To the Hospital 🔼 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

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Registrar

State

31. Date filed (Month, Day, Year) JUN 0 6 2007

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29b. Signature and title of

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



stated.

29c. License number

D20352

29d. Date signed (Month, Day, Year)

June 5, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year 0845 M av 0 Jun 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner SUBUV 09 tresda ban Dmel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day, 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 1 x M 2 □ F China Director 555-85-3408 1920June 15, Usual Residence of Decedent filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy hjury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No MD Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10250 Westlake Dr. #215 20817 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify þ 3 ☐ Widowed 4 ☐ Divorced Asian Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Plant Manager Dayton Electronics 4yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wu <u>Pingji Yau</u> unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14102 Tatani Dr. Boyds, Md. 20841 19a. Informant's Name/Relationship (Type. Print) Paul Yau/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 6-7-07 Alexandria, VA. Marshall's Funeral Home, Inc. 4217 9th St. N.W. Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of vision or Vital Records, P.O. Box 68760 attending physician 5480 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 4018019 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2K No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending -1-07 FAII investigation М 1 ☐ Yes 2 ☑ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 10350 CV4511 a to 1) r determined 4 Homicide Betherna, mo Home 29a. Certifier 🗷 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe all 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ste ern. On. 4-7525 A. DAER MO 32. Registrar's Signatur State Registrar

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8760,	Physician /Medical Examiner physician and physician and physician and physician sit is prize to the physician physic	icai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (o	r as a consequence of a conse	uence of):	spira tery	d,	ry a	12	1			
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	Sta Registi		31. Date filed (Month, Day, Year)  JUN 0 5		gistrar's Signa	K A	rester							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year **Physician** Allen Beatrice 03:15 AM a007 JUN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University
5. Social Security Number OF Mayland Medical Center a If Under 24 Hrs. 8 Date of Birth (Month, Day, Year) If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 270F 214-80-3950 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director timor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 2 No 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Ho Specify: þ 3 Widowed 4 Divorced natural Health and Mental Hygiene. tem 27 is marked other than "natur other traumatic event, the Medical Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be 19b. Mailing Address Street and Number or Rural Route Number. Item 27 206 20a. Method of Disposition Place of Disposition (Name of permit. Pages 1
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any injury or oti 1 ▶ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral ervice 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Intracerebra /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform 1∐ Yes 2 2 No 2 □ No 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) 1 Tes 2₩ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours atter death

To the Funeral Director:
completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) Jun. 17. 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bennis Himee 22 Baltimore mo 21201 South 31. Date filed (Month, Day, Year) 32. Registrar's Şignature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 17 per file 868 6-22-07 yt. State of Maryland Bepartment of Health and Mental Hygiene (17) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year C. Anderson 18-55 PM 2007 Emma /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Sinan Hospital 01 Baltmore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 04-04-1933 Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🕅 F 219 · 28 · 8153 Usual Residence of Decedent Director MD 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiens. In Properties 1, I flem 2, 13a or 28a-f show Important: I flem 7 is marked other than "natural", or I flems 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Balti more 1 ☐ Yes 2 No Directo OWINGS MILS 10e. Street and Number 10g. Citizen of What Country? U.S.A Court by Funeral hins 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes, 20 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 Divorced lach Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health Care ears William 4 1 17. Father's Name (First, Middle, Last) **Grimes** 18. Mother's Name (First, Middle, Maiden Surname) Be 2 ottie Unhain 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anderson / Daughte Owngs mills md enise nins court 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Bunal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) do:21.2007 Baltimore, MO reenmount 22. Name and Address of Facility Vough C. Cirecre Puneral Dervice 21. Signature of Funeral Service Licensee 23a. Part1. Enterine disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Mandallstan MO 21133 Immediate Cause (Final disease or condition resulting in death) Physician Sepsis days /Medical Due to (or as a consequence of): **Examiner** Unrescitable months Pancreatic Cancer. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit Perfora ted the death certificate be executed pyloric Due to (or as a consequence of): Box 68760 Physician/Medical as IF FEMALE: for use a 23c. If yes, outcome pf pregnancy (
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year 5 ☐ Other (specify) P.O. I ed by the a detached f 9☐Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, p 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown certificate has been s rector, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 2 No Division or Vital 1□ Yes 1 ☐ Yes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient ဠ 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of al or Attending P after death. I Director: After t 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation Injury 1 □ Natural 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 7. IN from histage To the Hospital of within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 06-17-2007 SURGERY RESIDENT M.D SM 20844 AS 240 2321 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bullinore SANJAY MUNICEDDY 2401 W. Belvedere Are. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 1 Registrar 2007

DHMH 17 Rev 1/2001

ANDERSON

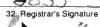
**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2007 JUNE 18 **Physician** MARIE C. AUSTIN 9:20a M /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A 1100 PENNA, AVE, APT 514 BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9-20-1930 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 □ XF Months Hours Min. Country) MARYLAND 212-28-0220 76 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "naturel", or Iteme 23a or 28a-f show treumatic event, the Madical Examiner must be notified at 1 √Yes 2 □ No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 1100 PENNA. AVE. APT 514 21201 USA Be Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 1 ☐ Yes 2 💥 No If Yes, Give Year or Dates: Saltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 No Specify: 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)
-11-College (1-4or 5+) LAUNDRY COYNE TEXTILES permit. Pages 1 and 2 should be fils Department of Health and Mental Hy Important: If Item 27 is marked other only injury or other treumstic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) CAREY LEE CRAIG SR. GEORGIANA RUSTIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1100 PENNA. AVE. APT 514 BALTIMORE, MARYLAND STANLEY AUSTIN (HUSBAND) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State LOUDON PARK CEMETERY 6-22-2007 BALTIMORE, MARYLAND 4 □ Donation /5 □ Other (Specify) HIBNER 2. Name and Address of Facility REDD FUNERAL SERVICE 21. Signature of Funeral Service Lifensee ONATHAN 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, 23a, Part1, E Onset and Death mmediate Cause (Final End Stage Long
Due to (or as a consequence of): **Physician** DISEASE disease or condition resulting in death) /Medical Examiner mp 5-quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cance Examiner Due to (or as a cons uence The law requires that the death certificate be executed use as the burial-transi Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, ettending physician Physician/Medical d IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificete 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 1 No or Attending Physicien: ours aftar death.

neral Director; After this certific tilled in by the tuneral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Tesidence 6 Other (Specify) ၉ 1 ☐ Yes 2 ☑ No 28c. Injury at Work? 27. Manney of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Deburah 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007



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Ave

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 6 Day Year **Physician** 0800A M BRISCOE WHO 17 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LEVINDALE GERIATRIC CENTER BALTIMORE NA If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral .11 M 2□ F Months Days 220-14-6437 81 Director AUG, 16,1925 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1 Yes No MD BALTIMORE BALTIMORE Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 818 HOPEWOOD ROAD 21208 USA Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Marvland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th NA HOME IMPROVEMENT SELF-EMPLOYED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ALEX BRISCOE 2 MARIE GRAY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BERDETTA WHITE - DAUGHTER 818 HOPEWOOD RD BALTO., MD21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🔀 βurial 2 □ Cremation 3 □ Removal from State 4 ☐ Conation 5 ☐ Other (Specify) GARRISON FOREST VET 6/25/07 OWINGS MILLS, neral Service Licensee 22. Name and Address of Facility 21. Sign MARCHWELL WESTE, BALTIMORE, 23a. Part . Enter the disease, or complications that cause shock, or heart failure. List only one cause on each i d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mmediate Cause (Final CARDIOVASCULAR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** CARDIAZ ARRYTIMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) BUMBE Cinonin TRIERY To the Hospital or Attending Physician: The law requires that the death certificate be exect within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1Ltsp1247VRV 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0064533 PMYSICIAN LEVINDALE -CACRUMINIC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEBREW W-BELVEDERE ATMINDE

Registrar
DHMH 17 Rev 1/2001

State

32 Registrar's Signature

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Baltimore, MD 21215-003 pennir. Pages I and 2 should be filed within Department of Health and Mental Hygene. Important: If item 27 is marked other it injury or other traumatic event, the Med	Be C	17. Father's Name (First, Middle, Last)	D				Name (First, Middle,		,		
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Baltimore, permit. Pages I ar Department of Hee Important: If ite	1	Donation 5 Other Specify: 21. Dignature neral Service Licensee			Name and Addres						
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,		30. Name and address of person who completed cause		23a)							
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month 4:33 A M 2007 **Physician** 9 JUNE Frank E Bryant /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner University of Maryland Medical Center Baltimore N/A If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 XM 2 □ F Yrs Jan. 27. 1931 Maryland 218-26-8331 76 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10b. County 10a, State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Lansdowne Baltimore 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21227
Was Decedent of Hispanic Origin? (Specity Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Completed by Funeral 2965 Bero Road Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2 🕅 No Specify Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Printing Company Pressman 18. Mother's Name (First, Middle, Maiden Surname) Alth and Mental Hyong Is mark traumatic event. 17. Father's Name (First, Middle, Last) Be Edith Bryant Frank Bryant, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2965 Bero Road, Lansdowne, MD 21227 Betty Bryant - Wife permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other trai once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c, Location - City or Town, State 20a. Method of Disposition Bunal 2 ☐ Cremation 3 ☐ Removal from State 6-12-2007 Mt Zion Cemetery Lansdowne, MD Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. ature of Funeral Service License 2719 Hammonds Fry Rd., Lansdowne, MD 21227 23a. Part . Enter the disease, or complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final one week Cardiogenic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Corony By By Due to (or as a consequence of): Aartic Valve Replacement Surgery Examiner one week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Arter Coronary burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician Aorfic Value Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death nse 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ate has been signed by the atterpage 2 should be detached for a in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ►No 24a. Was an was a... autopsy performed? Vas 2 No certificate 26. Place of Death (Check only one 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 1.2 Inpatient ٩ 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d Describe how injury occurred after death. 27 Manner of Death Medical Certification: 5 Pending investigation Hospital or Attending 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide To the Hospital within 24 hours a To the Funeral I completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifiei (Check only one) and manner stated.

Maryland 21215-0036

Baltimore.

State Registrar

29b. Signature and title of certifier

Charles 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Surgical Fellow

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Drummond, II, M.D.

29c. License number

29d. Date signed (Month, Day, Year)

6/14/07

22 South Greene St. Beltimore, MD 21201

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Linda Jean Bauern		umb For State	St	ate of Mary	rland / I	Departr Certifi	ment of icate of	Health Death	and	Menta	al Hyg		na No	2.5	107	2002
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Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	Completed	17. Father's Name	(First, Middl	e, Last)					1	8.Mother'	s Name (	First, Middle	, Maide dri (	n Surname) Ch		
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Physician	$\dashv$	23a. Part I. Enter	the disease,	or complications	hat caused	the death. I	Do not enter	the mode	of dying.	such as o	ardiac or	respiratory a	arrest, s	hock, or heart	Appi	veen Onset and
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L. K.		30 Name and	address of	erson who comple	ed cause o	f death (Iter	n 23a)									
D Sa		Susan H		Assistant	Medical	Examine	r 111 F	enn Str	reet, B	altimore	e, MD 2	1201				
	itat	31. Date filed (A	Month, Day,		32 Regis	trar's Signat	ture									
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)~	Examin	er	4a. Facility Name (If not institution, give s FOREST HILL HEALTH		TTATT		b. City, Town, or DREST H		eath		County of Death	
ì	Funeral		5. Social Security Number 6. Sex		In yrs. last bi	irthday)	f Under 1 Year  Months Days	If Under 24 I	Ain. (Month, D	rth a <i>y, Year)</i>	9. Birth	place (State or Foreign
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	show ed at	'n	10a. State 10b. County Maryland Harford	11	oc. City, Tow Bel A		ion					10d. Inside City Limits 1 ☐ Yes 2 No
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0	2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. 1 Is marked other than "natural", or Items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	Funeral		2. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No	er in U.S.		s Decedent of H es, specify Cuba	ispanic Origin' an, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	0-	14. Race - Amen Black, White	
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and	ld be f lental I ked of	To Be	Thomas Franklin M	orrison					Elizabeth		,	
ary	and M	-	19a. Informant's Name/Relationship (Typ	e. Print)	19	b. Mailing A	Address (Street	and Number o	r Rural Route Numb	ber, City o	or Town, State, Zi	p Code)
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E	permit. Pages 1 and 2 should be Department of Health and Ments Important: If Item 27 Is marked any Injury or other traumatic evence.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State			on (Name of ory or other place	_1	Date		ocation - City or T	
	artmer artmer ortant Injury		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	e	Harfo		emorial				erdeen, I	Maryland
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	100		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the cause on each line.	e death. Do							Approximate Interval Between
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<i>'</i>	/Medical Examiner		resulting in death)	Due to (or as a c	onsequence	of):						
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DIVISION OF	al or Atte after des I Directo d in by th	Certification:	3 Suicide 4 Homicide determined determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)								ral Route Number,	
	To the Hospital or Attending Physician: The i within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical C		ician: To the best of r er: On the basis of ex and manner stated	kamination a							
	To th within To th comp	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. Da	te signed (Month	, Day, Year)
	/		Dews 50				03	225	5	30	Ne 15	2002
	h		30. Name and address of person who con	npleted cause of deat	th (Item 23a)	(Type, Prin		-				,

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)
JUN 2 1 2007

DR. DAVID DUNN - 615 W.MACPHAIL ROAD - BEL AIR, MD 21014

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year VERNITA BUTTERWORTH June 18 2007 1:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Cherry Lane Nursing Home Laurel Prince George's 5. Social Security Number if Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) West Virginia **Funeral** Days Hours 1 □ M Director 76 106-24-8999 June 30 1930 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3404 Bitterwood Place USA by Funeral 20724 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes M No If Yes, Give Year or Dates: Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Program Analyst US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leslie Butterworth ٩ Thelma Horns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Jackson/Son 4813 Lakeview Lane, Bowie, MD 20720 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Lincoln Cemetery 6/22/2007 Brentwood, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, Laurel, 23a. Part inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat se (Final disease or condition resulting in death) Physician Metastatic Lung Cancer 6-9 Months /Medical Due to (or as a consequence of): Examiner Aspiration Pneumonia Sequentially list conditions, 3 Weeks Examiner cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of ig physician and as the burial-transit The law requires that the death certificate be executed Failure to Thrive 3-4 Weeks that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 1 ☐ Yes 2 🕱 No 9□Unknown 9 Unknown signed I be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Pulmonary Embolism 1 ☐ Yes 2 ☐ No 3 ☐ X Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No HTN autopsy performed? Yes 2 No page CAD 1∐ Yes or Attending Physiclan: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 ☐ Homicide filled 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29b. Signature and title of certifier ATTEMDIN G 29d. Date signed (Month, Day, Year) · marcacher BHYD CIAN D0057216 June 18, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Baako, MD 3450 Fort Meade Rd, #209 Laurel, MD 31. Date filed (Mon 1, Pay, Zea b) 2007 32 Registrar's Signature State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 8/15 3. Time of Death **Physician** ANNABELLE MARIE BENNETT uno /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PG Doctors Community Hospital Lanham, MD 8. Date of Birth (Month, Day, Year) Jan. 15, 1942 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 □ M 2 1 F Washington, DC 65 Director 577-54-7827 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits a or 28a-f show t be notified at 1 ∏Yes 2 ☐ No Director MD PG Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5721 South Marwood Blvd. 20772 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Black Specify. 3 ☐ Widowed 4 ☑ Divorced er than "nature , the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within th and Mental Hygiene. 7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Federal Government <u>Program Analyst</u> or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Boisy Davis Edna Goins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2730 Red Oak Lane, Glenarden, MD 20706 Karen Coley 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial Cemetery 6/15/07 Suitland, MD 4 Donation 5 □ Other (Specify) 21. Signatur uneral Service Lio 22. Name and Address of Facility Austin Royster Funeral Home <u> 3821 - 14th Street, N.W., Wash., DC 20011</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final & yaus **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (or as a consequence of) Examiner Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 200 3 Probably 4 ☐Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ Vo 24a Was an page 2 s director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident death. 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: 24 hours after death Funeral Director: filled in by the within 24 hor To the Fune completely fi To the

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State Registrar

Medical

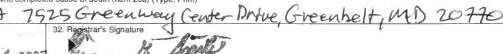
VEYZLUA 31. Date filed (Month, Day, Year)

30. Name and address

29a. Certifier

(Check only

29b. Signature and title of certifier



of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

**ORIGINAL** 

the certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 1,5tate of Maryland / Department of Health and Mental Hygiene rar Certificate of Death Reg. No. 1 - For A State Registrar 1. Decedent's Name (First, Middle, Last) Carroll Month

**Physician** /Medical Examiner

Sex ast birthday If Under **Funeral** Months 1 ☐ M 2 ☐ F 215-32-6875 Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c Town or Location 10h. County or Items 23a or 28a-f show aminer must be notified at **Funeral Director** 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 11. Marital Status other traumatic event, the Medical Examiner 1 Never Married 2 Married Maryland 21215-0036 Completed by 3 ☐ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) ngary (0-12) College (1-4or 5+) 17. Hather's Name (First, Mide Be 2 9a. Informant's Name/Relationship Koxanne 1. Baltimore, Method of Disposition 9 1 Burial 2 Cremation 3 Removal from State injury 5 ☐ Other (Specify) any in 23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Physician Due to or as a consequence of): /Medical Examiner LANCE Sequentially list conditions, if any, leading to immediate cause. Enter of use ying Cause (Disease or injury that initialed events resulting in death) Last Due to (or a // consequence of): Physician/Medical Examiner law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician the for use as attending IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death the detached 9□Unknown 9 Unknown signed by the Completed by page 2 should peen has certificate or Attending Physician: 25. Was case referred to medical examiner? furieral director, Be Hospital: 200 No 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death Date of Injury 28b. Time of (Month, Day Year) 1 Natural 5 Pending investigation Injury 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide filled in by 4 Homicide Hospital Medical 29a. Certifier completely (Check only one) and manner stated. the 29b. Signature and title of certifier e 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7246 A. Registrar's Signation 1/11/7 31. Date filed (Mont) 1 2007 State

2. Date of Death 06/13/2007 3. Time of Death Peggy DD 4a. Facility Name (If not institution give street and number) 4b. City, Town, or Location of Death County of D Year (State or Foreign 8. Date of Birth (Month, Day, 1935) Birthplace Country) Days 10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 228 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 No Specify 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT usevetire)

Bus Hid 18. Mother's Name (First, Middle Maiden Surname d Number or Rural Route Number. City or Town, State, Zip Code) Owings Mills, MD 21117 20c. Location disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Approximate Interval Between Onset and Death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 🔽 No 1 Tyes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 XNo 1∐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28c. Injury at Work? 1 □ Yes 2 □ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) i 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2007 20025 1- For State Certificate of Death Reg. No. Registrar . Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Month 2207 hrs Medical Examiner June 18, 2007 Carter Antonio David 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital **Baltimore** 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** Months Days Hours Min Director 06 17 81 1 X M 2 Country) 213-98-0684 26 Usual Residence of Decedent I0c. City, Town or Location 10d. Inside City Limits 10a. State 23a or 28a-f show notified at once. 1 X Yes 2 No Baltimore NA MIC hours after death with the Maryland Director 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code U.S.A. 3408 St. 21215 Ambrose Ave Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, tenis Armed Forces? White etc. 1 X Never Married 2 Married 0r. Yes 2 X No Widowed Divorced If Yes Give Yes Yes 2 X No specify Specify: Black "natural". ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed saltimore, MD 21215-0036
rmit. Pages 1 and 2 should be filed within 72 hox
portnert of Health and Mental Hygiene. during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Industrial Worker Factory 2th grade na 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Sumame) # Be event, Elister Clark Floyd Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Md 21215 Ambrose Ave, Mrs Carter-Parent item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 5/26/07 Loudon Park Baltimore, Md Monation 5 Other Specify 22 Name and Address of Facility March F/H West 4300 Wabash Ave, ture of Funeral Service License 21215 Baltimore, Md Part I. Enter the disease, or commediations to train cations to the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical Death Gunshot Wounds (2) to the Head and Hand Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last LIVISION Of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be execute hin 24 hours after death. attending physician and for use as the burial - tran Physician/Medical UNPENDED AMENDED 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown q Linknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been s ector, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other<sub>4</sub> ER/Outpatient 3 V DOA Other this Inpatient 2 Nursing Home 5 Residence 6 1 Yes 2 No 28a. Date of Injury (Month, Day Year) Jun 18, 2007 After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot Natural 2133 hrs Pending Yes 2 ✔ No Director: Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 3408 St. Ambrose Ave, Baltimore, MD determined 4 V Homicide (Specify) Local Street Funeral 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 1 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number OCME June 19, 2007 3 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day) 32. Registrar's Signature State MELKE

Registrar

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		Baltimore County Detention Center		To	owson				Baltimore Co	
Funeral Director			(In yrs. last	N N	Under 1 Ye		4Hrs. 8. Date of B	irth(MM/	DD/YYYY) 9. Bi Forei	rthplace (State or
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with the Maryland as 23a or 28a-f sho		7333 Berkshire Road  11. Marital Status 12. Was Decedent E	una i= II C	140.00		1224	K		USA	
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/Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease a. Atherosclero					c of respiratory are	est, snot	ok, or neart	Approximate Interval Between Onset and Death
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ViSion Attender des in by ti	Ea	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury	- At home, t	farm, street, facto			28f Location (S	troot and	I Number on Dur	al Route Number, City
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To the Howithin 24 h		29a. Certifier 1 Certifying Physician: To the best of my krone) 2 Medical Examiner: On the basis of examine	nowledge, de	eath occurred at t	ne time, dat	e and place, ar	nd due to the cause	(s) and r	manner as stated	i.
T take to a	Medical	2 Medical Examiner: On the basis of examiner and manner stated.  9b. Signature and title of certifier			ny opinion, 9c. License		at the time, date a			
		Man Beauch Mix			O.C.N				te signed (Mont 19, 2007	h, Day, Year)
	3	0. Name and address of person who completed cause of death	(Item 23a)					30110		
	2	Melissa Brassell, MD Assistant Medical Ex		111 Penn S	treet, Ba	Itimore, ME	21201			
Star Registra		1. Date filed (Month, Day, Year)  JUN 2 1 2007  32. Surstrar's S	ignature	A. K.						
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	Dhyaiai		1. Decedent's Name (First, Middle,		<u> </u>				<ol><li>Date of Dea Month</li></ol>	Day	Year	3. Time of Death
	Physicia Medic	_	Mary	16. (	reag	21			June		007	2.19AM
	Examin		4a. Facility Name (If not institution,	give street and no	umber)		4b. City, Town, or	Location of Death		4c. Coun	ty of Death	
1			Howard County		Hospital			ımbia If Under 24 Hrs.	8. Date of Birth	Howar	rd Cou	nty ace (State or Foreign
	Funeral		5. Social Security Number 218-36-7600	6. Sex 1 ☐ M 2 🕱 F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	(Month, Day	, Year)	Coun	try)
2	Director		Usual Residence of Decedent		65				6/20/4	+1	West	Virginia
	and	-	10a. State 10b. County		10c. Cit	y, Town or Lo	ocation				1	Od. Inside City Limits
	Mary f sho ied a	jo	MD How	ard			Ellicott	City				1 ∐Yes 2 No
	the 28a-	Director	10e. Street and Number	aru			10f. Zip Code	Olcy		l 0g. Citizen o	f What Coun	try?
	3a ol		3961 Ducks Fo	ot Lane				21042		US	SA	
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural" or items 23a or 28a-f show int, the Medical Examiner must be notified at	Funeral	11. Marital Status		cedent Ever in U	.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No-	14. Ra	ace - Americ ack, White,	
9	after or ite		1 ☐ Never Married 2 ☐ Marri		2 No		1 □ Yes 2 1 No	Specify:	, , , , , , , , , , , , , , , , , , , ,	Spec		
5-0036	ours iral", Exa	d by	3 ☐ Widowed 4 🔀 Divorced	Year or	Dates:						Wh	ite
, L	72 h 'natu dical	Completed	15. Decedent (Specify only highes	s Education t grade completed	)	I (Give	dent's Usual Occupa kind of work done of DO NOT use retired	luring most of work	ring	16b. Kind of	Business/Ind	dustry
[2]	vithin ine. han '	mp	Elementary/Secondary (0-12)	1 -	(1-4or 5+)		Communicat	,		ΛΛ (	ounts.	Police
N	e filed v al Hygie other t vent, th		12 17. Father's Name ( <i>First, Middle,</i>	0			Johnnun 1 Cat	18. Mother's Nam	e (First, Middle,			TOLICE
ano	be ad o	Be	,	2001)				Можи	F. Fior	ntino		
Maryland	should be filed ind Mental Hygi marked other matic event, t	မ	John Riley  19a. Informant's Name/Relationsh	nip (Type, Print)	-	19b. Maili	ng Address (Street a				n, State, Zip	Code)
<u>8</u>	nd 2 sho Ith and 27 is ma		Mr. Joseph Rile		other	3961	Ducks Fo	ot Lane	Ellico	tt City	y, Md.	21042
ā,	s 1 and 2 should of Health and Mer item 27 is marker other traumatic	li	20a. Method of Disposition	<i></i>	20b. F		osition (Name of matory or other place		Date	20c. Location		
ē			1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		n State		ark Cemete	1	/07	Balti	nore.	Maryland
altimore,	permit. Page Department of Important: If any injury of once.		21. Signature of Funeral Service		) 1200	2	2. Name and Addres	ss of Facility Lo	udon Pa			
ñ	Imp per any any any		1 Eugen	J. Ca	mo 1	7 3	3620 Wilke	ens Ave.	Baltimo	re, Ma	ryland	21229
	# 194 y		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	t caused the deat	th. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			erebe		leed			1	Onset and Death
	/Medical		resulting in death)	_ a.		-			n í	7. 4.5	. 0	
II.	Examiner		Sequentially list conditions				ic Caro	tuovasc	Wow !	JULIO		
	p #	juer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a consec	quence of):						
	ecute and -trans	Examiner	that initiated events resulting in death) Last	C	o (or as a consec	allence of).					-	
760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit				0 (0. 45 4 55.1955	,						
ထ	icate physi s the I	dical		d	=======================================							
9 X	leath certific attending p	Physician/Med	IF FEMALE:	23c. If yes, c	utcome pf pregn					23d. I	Date of delive	ery
Box	atter for u	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No		e birth 2  Feta gnant at time of a		□Ectopic pregnancy □ Other <i>(specify)</i>	/			Month	Day Year
o.	the d y the iched	ıysi	9 ☐ Unknown	9□Uni	known							
υ, σ	uires that the de signed by the a Id be detached f	by Pł	Part II. Other significant condition	ns contributing to	death but not res	sulting in the u	underlying cause giv	en in Part I.	23e. Did to	obacco use co	ontribute to t	he cause of death?
rds S	w requires been sign should be								10	/es 2∐No	3 ☐ Proi	pably 4 □ bhknown
Records,	aw re s bee	Completed							24a. Was		b. Were auto	opsy findings available impletion of cause of
ď	The I	lmo.							perfo	rmed?	death? 1 ☐ Yes	2 ☑ 100
Vital	sician: The law certificate has l irector, page 2 s	Be C	25. Was case referred to medica examiner?			7		26. Place of Dea	th Check onl	ne		
>	Physician: r this certificanal director, I	To	1 Yes 2 No	Hospital: 1 [	Inpatient 2	ER/Outpatie	ent 3 DOA Oth	4 🗆 Nursing n	ome 5□Resi	dence 6 🗆 0	Other (Speci	fy)
0	ng Pl	ü	27. Manner of Death 1 ☑ Natural 5 ☑ Pendin	/6.6	te of Injury onth, Day Year)	28b. Time of Injury	Wor		28d. Describe	now injury occ	curred	
Sio	tendi eath. or: A	catic	2 Accident investignment inve	gation	77.1			Yes 2 □ No	2001 1 11 7	244		al Flauta Mumbay
Division or	or At fter d Jirect in by	Certification:	4 ☐ Homicide determ	inod   Zoe, Fla	ice of injury - At n ilding, etc. (Speci	ify)	treet, factory, office		City or To	vn, State)	mber or Aur	al Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director; After this certificate his completely filled in by the funeral director, page		200 Cartifice 1 Providuis	a Physician: To	the heet of my kn	owledge dea	th occurred at the ti	me date and place	and due to the	cause(s) and	manner as	stated.
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 Certifyir (Check only one) 2 Medical	Evaminer: On the	hacie of avamin	ation and/or i	nvestigation in my (	oninion, death occu	irred at the time.	date and place	ce, and due t	o the cause(s)
	ithin ithe	Mec	29b. Signature and title of certifie	r	umor diatour		29c. Licens	e number		29d. Date sig	ned (Month,	Day, Year)
	or with	1	+ 4	agun			-	D3064	-1	Jun	e15	2007
	1)		30. Name and address of person	who completed or	ause of death (Ite	m 23a) (Type	, Print)	7 -0 0 7	1	0 11		11 1 1
	5	1 3		athi 2	01-109	Pac	k River	NICK	12000	139/11	muse	Mayland 21221
	St	ate	31. Date filed (Month, Day, Year)	82	. Registrar's Sign	nature	W -					Day, Year) 2007 Mayland 422
	Regist	rar	JUN 2 1 21	107 AS	ear A	God						

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	,	Certifica	te of	Death		F	leg. No.	200	1 2002
Physicia	ın/	Decedent's Name (First, Middle,Last)		v				Date of Dea     Month	ath	Year	3. Time of Death
/ledical Exami	Iical Examiner         Anna A. Coleman           4a. Facility Name (if not institution, give street and number)         4b. City, Town, or Location or Loca										0630 hrs
		· · ·	street and number)		4	-	ocation of Dea	ath	1	nty of Death	
		2748 Riggs Road	1			Baltimore	Tirri 1 041	L. la D. L. (D)	N / A s. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State		
Funeral Director		5. Social Security Number 6. Sex		yrs. last birth	day)	If Under 1 Year Months Days	If Under 24F Hours M	lin	•	Foreign	n .
Birector	1		M 2XF 8	3	Yrs.			5/31	/1924	Cou	intry) MD
A SCHOOL SECOND A CO. AVE I CO. A	****	Usual Residence of Decedent  10a. State 10b. County	110c.	City, Town o	r Locatio	on	-	-			10d. Inside City Limits
ا ۽ ڇ	.			•							1 X Yes 2 No
Aaryland 28a-f show 1 at once.	흸	Md. N/A		altim	101.6	10f. Zip Code			10g. Citizen o	f What Coun	
te Ma or 28	Director	2748 Riggs Ave	, m.11.0			21216	c		US		.,.
vith th s 23a e noti	11. Marital Status 1 Never Married 2 Married Armed Forces? 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue										can Indian, Black,
eath 1										Vhite, etc.	
ifter d		3 X Widowed 4 Divorced	1 Yes 2 X	NO	1	Yes 2X No	specify:		Spec	ify: Bla	.ck
5-0036 led within 72 hours afte tygiene. other than "natural", the Medical Examine.	d by	15. Decedent's Education (Specify on	y highest grade complete			's Usual Occupations of working life.			16b. Kind o	of Business/Ir	ndustry
136 thin 72 h re. than "n edical E	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)				DO NOT user	etired)			
003 within iene.	鬞	12		H	lome	maker			Own	Hom	ie
15-00 filed with al Hygien ed other t, the Me		17. Father's Name (First, Middle, Last)						me (First, Middle,		ame)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	o Be	Clifton Howard  19a. Informant's Name/Relationship (Ty		19h	Mailing	Address (Street	Mariah			Town State	Zin Codo)
MD 21215 d 2 should be file th and Mental H n 27 is marked of umatic event, il		Sharon Gaither	po, , , , , , , ,	W		Riggs A			•		1 1
_ 2 = 5 %		20a. Method of Disposition		20b. Place of	Disposi	tion (Name of cerr		Date	<u> </u>	ion - City or	
<b>5</b> % ₽ = []		1 Burial 2 X Cremation 3			•	erplace) ematory	. 6	'28 /200	7 Cot	onaui	lle, Md.
Baltimo Permit. Pag Department Important:	-	Donation 5 Other Specify:		Metro			of Facility	20/200	1 Cat	UIISVI	ite, Mu.
Balt permit Depart Impor injury		Wound VIIS	- 5 km	<del>/</del>	世S 13	ame and Address tep Bro 00 Eut:	others aw Dla	Funer Ce Ba	al Hoi Itimo:	me, P re Md	A 1. 21217
Physician		23a. Part I. Enjer the disease, or compl		eath. Do not	enter th	e mode of dying,	such as cardia	c or respiratory a	rest, shock, o	r heart	Approximate Interval
/Medical Examiner		failure. List only one cause on each lmmediate Cause (Final disease a. /	atherosclerotic Car	diovascula	ar Dise	ease					Between Onset and Death
-Aaiiniici		and the second s	Oue to (or as a conseque	nce of):							
	اءِ ا	Sequentially list conditions,	No to /or on a conseque	200 of\:						55	
	Ē	if any, leading to immediate Due to (or as a consequence of):  Consequence of injury that initiated Consequence of injury that inju									
17 E - [4]	Examiner	events resulting in death) Last	Due to (or as a conseque	nce of):			-			_	
executed an and al - transil		d									
40 15 15	/Medical	UNPENDED	AMENDED								
	Ž	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of 1 Live birth		Ent	al death 3	Ectopic pres	mancy	23d. Da Mon	te of delivery	/ Day Year
x 6.8 h cert tendir	icia	past 12 months?	4 Pregnant at time	of death 5	=	ner (Specify)		jiranoy	l won		ray rear
Box e death c the atten	Physician	1 Yes 2 V No 9 Unknown	9 Unknown								
P.O. Box 687 es that the death certific igned by the attending p	by P	Part II. Other significant conditions	contributing to death but	not resulting	in the u	nderlying cause g	iven in Part I.				the cause of death?
S, F uires I n sign Id be	g	-						-			pably 4 Unknown
ords, w requir	Completed								ppsy	prior to c	topsy findings available completion of cause of
Rec The la icate h	E								ormed? 2 ✔ No	death?	es 2 No
cian:	Bec	25. Was case referred to medical examiner?					of Death (Che	ck only one)			N
of Vital Records, ng Physician: The law require Nfer this certificate has been si nneral director, page 2 should b	ם	1 ✓ Yes 2 No	ospital: 1 Inpatient		tpatient			sing Home 5		6 🗸 Other	: Scene
ion of rending Pheath.		27. Manner of Death  1  Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. T	ime of Ir		y at Work?	28d. Describe	how injury or	ccurred	
SiOr Attend death ctor: y the	ä	2 Accident 5 Pending Investigation					′es 2 No				
Division Spital or Attendithours after death.	Certification:	3 Suicide 6 Could not be determined		- At home, far	m, stree	t, factory, office b	uilding, etc.	28f. Location or Town,		umber or Ru	ral Route Number, City
Di Hospital 24 hours a Funeral	- 1	29a Certifier	(00 00)/					V	(-) 1		- 0
ap the First	igal	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
To To	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.    Check only one   2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.    29b. Signature and thite of certifier   29c. License number   29d. Date signed (Month, Day, Year)										
	O.C.M.E. June 19, 2007										
		30. Name and addless of person who o	ompleted cause of death	(Item 23a)					1		
4	ŀ	Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201									
	ate		32. Registrar's S	ignature		AF .					
Regis	trar	JUN 2 1 20	07 Malaka	15.	600	The state of the s					

		_	For State Registrar	State of	Maryland / i		artment of H		and Ment		ene 0 0 7	20030
			Decedent's Name (First, Middle	, Last)			<del></del>			ate of Death	Day Year	3. Time of Death
	Physici		John Edward Cus	ack, Jr.						ne 18,		7:45 P M
	/Medic Examin		4a. Facility Name (If not institution,		ber)		4b. City, Town, or	Location o	of Death		4c. County of Deat	th
			Charlotte Hall				Charlott				St. Mary'	
	Funeral		5. Social Security Number	6. Sex 7	7. Age (In yrs. last bi	rthday) Yrs.	If Under 1 Year Months Days	Hours 1	Min. (A	ate of Birth Month, Day, Y	ear)	thplace (State or Foreign ountry)
	Director		037-12-9481 Usual Residence of Decedent	<b>K</b>	82	113.			Aug	12,1	.924 Knod	le Island
	land ow		10a. State 10b. County		10c. City, Tow	vn or Lo	cation					10d. Inside City Limits
	Many P-f sh	tor	Maryland Princ	e George's	Bowie							1X Yes 2 □ No
	or 284	Director	10e. Street and Number				10f. Zip Code			100	g. Citizen of What Co	ountry?
	23a d		12403 Stonehave	n Lane			20715			US		
	tems tems	Funeral	11. Marital Status	Armed For		13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Orig in, Mexican	gin? (Specify ` n, Puerto Ricar	Yes or No- n, etc.)	14. Race - Ame Black, Whit	
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Marri 3 🏿 Widowed 4 ☐ Divorced	IANT- City	2 □ No tes: <b>143-14</b> 6		1 ☐ Yes 2 🗓 No	Specify:			Specify: Wh	nite
8	be filed within 72 hours after death with the Maryland tial Hyglene.  ad other than "natural", or Items 23a or 28a-f show avent, Item or Items are notified at		15. Decedent	's Education		. Dece	ient's Usual Occupa	ation		16	6b. Kind of Business	
215	n 72	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-	4or 5+)	(Give	kind of work done of OO NOT use retired	during most ()	t of working			
21	filed within Hygiene. Ither than "	mo.		4		ngin	eer			De	partment	of Navy
nd	be filed vital Hygie od other lavent, II	Be (	17. Father's Name (First, Middle,						·		aiden Sumame)	
Maryland 21215-0036	2 should be t and Mental I is marked of raumatic ave	ဥ	John Edward Cus						y Sulli			7-0-4-1
Nar	d 2 should th and Men 7 Is marke traumatic		19a. Informant's Name/Relationsh								City or Town, State, .	Zip Code)
	l and Healt	1	John Cusack III  20a. Method of Disposition	/ Son	20b. Place of	of Dispo	Shadywood	-	Date		oc. Location - City or	Town, State
Baltimore,	of of		tXXBurial 2 ☐ Cremation		State cemete	ery, crei Mar v	natory or other plac 'land		6 /22 /20	007 Cs	cownsville	MD
턆	permit. Pag Department Important: I any injury o		*4 □Donation 5 □ Other (S <sub>i</sub> ) 21. Signature of Funeral Service		Vetera	ans	Cemetery  Name and Addres				Evans Fune	
Ba	Dep Impe		1 au d	/ -	00544						MD 20715	star nome
	= 1		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca	used the death. Do							Approximate Interval Between
	Priysician		Immediate Cause (Final disease or condition		elodusk	da	stic Si	inde	MME	>		Onset and Death
	/Medical		resulting in death)		or as a cons, luen		3170	),,,,,	, , , ,			
и	Examiner		Sequentially list conditions,	b. My	perten	sia	M					
	ed isit	Examiner	it ary, leading to immediate cause. Enter Underlying Cause (Disease or injury	Z Danie	r as a consequence	or):	1.0	-1	1.5 1/0	coul	andis	8000
	xecut and al-trar	xan	that initiated events resulting in death) Last	c. Due to (	or as a consequence	>VO	nc C	ana	aova	-3 COO		age
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical E		a Chr	omscle or as a consequence Onic	Ki	dney	Dis	sease	<u> </u>	tage V	
9	ifficate g phy as the	ledic										
Вох	death certifica attending ph d for use as t	M/us	IF FEMALE: 23b. Was decedent pregnant		come of pregnancy	h 3[	⊒Ectopic pregnancy	,			23d. Date of de Month	blivery Day Year
	s deal he att	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of death		Other (specify)				МОПП	Day real
P.0	that the de led by the a detached t	Phy	9 ☐ Unknown  Part II. Other significant condition	ne contributing to de	eath but not resulting	in the u	nderhing cause ou	en in Part I	5.25	23a. Did toba	acco use contribute t	to the cause of death?
	w requires that been signed is should be det	by	Dementi		au bat not rosoning	111 1110 0	indonying oddoo giv	OIT AT I GIVE				robably 4 Winknown
Ö	r requ	etec	Tu sotlan	roidis	m					24a. Was an	24h Were a	utopsy findings available
Records,	: The law cate has	Completed by	maporna	roidis	•					autopsy perform	prior to death?	completion of cause of
a		C	25. Was case referred to medical					26 Place	e of Death (Ch			s 2□No
of Vital	Physician: this certificant all director.	To B	examiner?	Hospital:	npatient 2 ER/C	Outpatie	nt 3 DOA Oth				ce 6 □Other (Spe	ecity)
וסו	g Phi ter thi		27. Manner of Death	28a. Date of	of Injury h, Day Year) 28b.	Time o	f 28c. Injur				v injury occurred	
ioi	endin sath. or: Aft he fur	atlo	1 Natural 5 Pendin 2 Accident investig	gation				Yes 2□				
Division	or Att ter de irect	Certification;	3 Suicide 6 Could determined	inna ZBB. Place	of Injury · At home, ng, etc. (Specify)	farm, st	reet, factory, office			Location (Stre City or Town,	eet and Number or R State)	Rural Houte Number,
	urs al pral D pral D		CO- C-diline 180 Conditain	ng Physicien: To the	hast of my knowledge	an door	h secured at the tire	ma data an	ad place, and	due to the car	ice(c) and manner a	es stated
	24 hos	Medical	29a. Certifier  (Check only 2 Medicel one)	Exeminer: On the ba	asis of examination a	ind/or in	ivestigation, in my o	pinion, dea	ath occurred a	t the time, dat	e and place, and du	e to the cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Me	29b. Signature and title of certifie				29c. Licens	e number		29	d. Date signed (Mon	oth, Dey, Year)
			V/01.0	Alan	im		DU	150	92	-	6/19	2007
	DOTI		30. Name and address of person	who completed caus	e of death (Item 23a	) (Type	Print)	- (	D	2	- 1	1
(	<b>グ</b>		110 Hospi	took K	cad s	Sic	ite 20	72	TYIV	icet	redvice	L, MD
		ate	31. Date filed (Month, Day, Year)  JUN 2 1 2	13	egistrar's Signature	PORA	les o					2067
	Regist	rai	JUNGIZ	UUI A COM	and for							

Registrar DHMH 17 Rev 1/2001

13

29b. Signature and title of certifier

WALEGO BOLAD

31. Date filed (Month, Day, Year)

JUN 2 1

WALEED

201 E. University

Poplar.

32. Begistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Parky

BOLAD M.D

29c. License number

AT2438946 Union Memorial 29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Corn **Physician** 0300AM une 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard County General Hospital olumbia Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours Min. 305-42-8077 March 15 1925 Director Indiana Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show "natural", or items 23a or 28a-f shov sdical Examiner must be notified at 1 X Yes 2 □ No Director Howard Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 21045 7110 Minstrel Way USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. other traumatic event, the Medical Examiner Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
Int: If item 27 Is marked other than "natural", or ite 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White à 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Military Advisor US Army 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Hannon ၉ Newton Corn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 2852 Jessup Road, Jessup, MD 20794 Sharon L. Harmon /Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National 8/22/2007 Arlington, VA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature et Funeral Service Licensee M01103 313 Talbott Avenue, Laurel, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) pneumonia days baderial **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 | Yes 2 | No 3 | Probably 4X Unknown tu sion 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ▼ No 24a. Was an has autopsy perform ten si an 2X□ No or Attending Physician: 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA 1 Ninpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Medical Certification: 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation after death. 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital or within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b Signature and title of certifier 56531 Jane 14, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harry Li, 8600 snowden River pkwy, suite 301, columbia, MD21045 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

07-04548 G۷

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wynn Cunningt	1-	State of Maryland / Department of He For State Certificate of De		Reg. No							
Physicia		egistrar i. Decedent's Name (First, Middle,Last)		2. Date of Death  Month Day	Year	3. Time of Death 0850 hrs					
ıl Exami		Gwynn Cunningham	ty, Town, or Location of Death	June 14, 2007	c. County of Death						
	4	4a. Facility Name (if not institution, give street and name)	Itimore		,						
			Inder 1 Year If Under 24Hrs.	. 8. Date of Birth (MI	M/DD/YYYY) 9. Birtl	place (State or					
Funeral Director			onths Days Hours Min.	Jan. 15,	1958 Foreign	intry) MD					
	Ŀ	Usual Residence of Decedent		10d. Inside City Limits							
v any		10a. State 10b. County 10c. City, Town or Location	m 1.1			1 X Yes 2 No					
daryland 28a-f show	ē.	MD	Baltimore Zip Code	try?							
Mary 28a-	Director	Toe. Street and Number			USA						
with the Maryland us 23a or 28a-f sho		806 West Lanvale Street  11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Dec	21217 cedent of Hispanic Origin? ( Sp		14. Race - Ameri	can Indian, Black,					
72 hours after death with the Maryland n "natural", or items 23a or 28a-f she ral Examiner must be notified at once	Funeral	1 X Never Married 2 Married Armed Forces?	pecify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.						
er des		1 Yes 2X No	2 x No specify:		African Specify:	American					
hours afte "natural", Examiner	g-	15 Decedent's Education (Specify only highest grade completed) 16a, Decedent's U	sual Occupation (Give kind of working life, DO NOT use ret		. Kind of Business/I	ndustry					
72 hot 1 "nat	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	-								
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21215-0036 wild be filed within 72 Mental Hygiene. marked other than '	ပ	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid Jessie Mae I							
21215 21215 buld be file Mental H marked of	o Be	Leroy Cunningham  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Add	dress (Street and Number or			, Zip Code)					
	۲	15a. Illiotinanto Hamer televisione (17)	Lanvale Street;								
nd 2 alth	1	20a. Method of Disposition 20b. Place of Disposition	(Name of cemetery,		c. Location - City or						
more Pages 1 nent of H ant: If it		1 Burial 2 Cremation 3 Removal from State Crematory or other p. Mount Zion Cem		21/2007 F	Baltimore, M	arvland					
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other to				Wylie Funera							
Ba Perm Depa Imp		January ( )	638 N. Gilmor S	treet: Balti	more, Maryl	and 21217					
`hysician	П	23a. Part I. Enter the disease, or comblications that caused the death. Do not enter the magniture. List only one cause on each line.	ode of dying, such as cardiac	or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and					
/Medical Examiner		Immediate Cause (Final disease a. Heroin intoxication and co	caine use			Death					
Lxaiiiiiei		or condition resulting in death)  Due to (or as a consequence of):									
	<u>-</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
	nin	cause. Enter Underlying Cause									
ig g W	Examiner	events resulting in death) Last  Due to (or as a consequence of):									
Records, P.O. Box 68760,  The law requires that the death certificate be executed crate has been signed by the attending physician and nage 2 should be detached for use as the burial - transit	cal	y unpended AMENDED 27,28a-f. perME. g86	0 6/25/07 mm								
50, te be o	Aedical	23c. If yes, outcome of pregnancy	08, 0/25/0/ 11		23d. Date of delive						
rtifica ing ph	an/N	23b. Was decedent pregnant in the past 12 months?		nancy	Month	Day Year					
ox 6 ath cel attend or use	sici	past 12 months?  4 Pregnant at time of death 5 Other  1 Yes 2 No 9 Unknown	(Specify)								
P.O. Box 6876 that the death certificat ned by the attending ph detached for use as the	Physician/N	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.			o the cause of death?					
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the rs after death.  In a Director. After this certificate has been signed by lad in by the fineral director mage 2 should be detail.	à			1 Yes	2 No 3 Pr	obably 4 V Unknown					
ds, equire	ompleted			24a. Was an autopsy		autopsy findings available completion of cause of					
COF law r has b	ě			perform							
Re: The ifficate	ទី	25. Was case referred to medical	26.Place of Death (Chec	-							
f Vital Physician: er this certif	98	examiner? Hospital: Inpatient 2 FR/Outpatient 3	DOA Other Nur	sing Home 5 Re	esidence 6 Oth	er:					
of V g Phy her th	유	1 ✓ Yes 2 No  27. Manner of Death  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury		28d. Describe ho	w injury occurred						
on on and ing asth.	ļ ģ	1 Natural 5 Pending Fnd 6/14/2007 unk	1 Yes 2 XNo	unk							
/iSi	fica	2 Accident Investigation 28e. Place of Injury - At home, farm, street,	factory, office building, etc.	or Town, Sta	te)	Rural Route Number, City					
Division of the price of the pr	Certification:	4 Homicide determined (Specify) alley			St. & N Call	noun St. Baltim					
Division of Vital Records, P.C. To the Hospital or Attending Physician: The law requires tha within 24 hours after death. To the funeral Director: After this certificate has been signed companies tilled in by the finieral director page 2 should be detailed.	la S										
To the Vithin To the	edic	and marrier stated.									
	Σ	29b. Signature and title of certifier	O.C.M.E.		June 15, 2007						
_	Carol Milas										
$\mathcal{A}$		30. Name and address of person who completed cause of death (Item 23a)  Carol Allan, MD Assistant Medical Examiner 111 Penn St	reet, Baltimore, MD 21	201							
<u> </u>	3	Pogistror's Signature									
	State	4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	<i>3.</i>								

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All District Amend #2, perMD, g808, 7/2/07 IT Certificate of Dooth

Certificate of Dooth 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death В Pay **18** Month **Physician** CORNISH Year DELMA 2007 Jun 0715 AM <del>16-</del> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and numb 4b. City, Town, or Location of Death Examiner Medical enter Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 10-2-19319. Birthplace (State or Foreign Months Days Hours Min. | 4 Month, Day, Year) | MD 5. Social Security Number 213267068 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 12 F Months Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f showing important: If tem 27 is marked other than "hadical Examiner must be notified at once.] 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County MD n/a 1 XYes 2 No Baltimore **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4718 Dunkirk Avenue 21229 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc.
African-1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. Specify: þ X3□Widowed 4□Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earl Morris Maryetta Straughn 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 581 Laurens Street, Balto. MD 21217 David Hendricks/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 6-25-07 Cheltenham Vet. Cheltenham, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Wylie F/ H P.A. of Balto.Co 21. Signature of Funeral Service Licenses 9200 Liberty Rd., Randallstown, MD 21133 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Approximate Interval Between Onset and Death Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner months can Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform After this certificate 2 No 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) the funeral 28b. Time of Mannerrof Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled In by determined 4 Homicide To the Hospital within 24 hours a To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a), (Type, Print) Pacu Meghan 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State JUN 2 1 Registrar

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	1	For State Registrar		rate or ivi	arylani	•	rtificate of			Reg. No.	17	20035
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Examiner	4	a. Facility Name (If not institut				,2	4b. City, Town, o	r Location of De	eath	4c. County	of Death	
		JOHNS HOPKING		11EWY	MEDIC	AL EVE	If Under 1 Year	3 PLT 1			N/A	Ctata as Fassian
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and w	h-	Jsual Residence of Decedent  0a. State 10b. Coun	tv		10c. City	, Town or Lo	cation				100	d. Inside City Limits
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s 1 ar f Hea item other	2	20a. Method of Disposition			0	lace of Dispo	sition (Name of matory or other place	1	Date	20c. Location -	City or Tow	n, State
Page nent o int: If		1 ☐ Burial 2 【XCremation 4 ☐ Donation 5 ☐ Other		oval from State			ematory,		/18/2007	Baltimo	ore, I	MD
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Commissed by Funeral Director		21. Signature of Funeral Service	steven	H Wil	liams	5 22			ety of Mar Road, Balt			1228
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The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit completed by Physician/Medical Framin		1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Pregnant a 9□Unknown	at time of de	eath 5□	Other (specify) _			Wo		oay real
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Ital or Attending Priss after death. ral Director: After ted in by the funers		4 ☐ Homicide dete		building, e	itc. (Specify	/)			City or Tow	m, State)		
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.  Madical Certification: To Be Commi					of examina				lace, and due to the occurred at the time,			
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: 4		D 1/0	108	yms	1	11)	DO	0536	11	06.1	9,20	001
3+1	1	30. Name and address of persons	on who comp	leted cause of	death (Item	23a) (Type, 4940		AVENUE	BALTIMOS	e mo	,21	224
State		31. Date filed (Month, Day, Yea	ar)	32. Regis	trar's Signa	ture	- Af a			/	<del></del>	•
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 31 per dyr 868 6-22-07 Walth and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Montb Day Year 1700 **Physician** 7005 Christine Davis /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore oF Mary Uzzverty If Under 1 Year | If Under 24 H Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Security Number **Funeral** Days Months Hours 1 □ M X □ F 74 Director 30 08 214-50-0001 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Funeral Director MD Baltimore Pikesville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U • S • A •
Race - American Indian,
Black, White, etc. 21208 8224 Arrowhead Road Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes X☐ No Specify: Baltimore, Maryland 21215-0036 Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th grade House na Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Lacy George Damon Morris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 30 Tallow Ct, Baltimore, Md 21244 <u>Oueen Davis-Daughter</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition N Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 6/25/07 Randallstown, Md 29a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh. k, or heart failure. List only one cause on each line.

In media e Cause (Final disease or condition resulting in death) 22. Name and Address of Facility
March F/H West 21. Agnature of pineral Service Licensee 21215 Baltimore, Approximate Interval Between Onset and Death Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and I for use as the burial-transit Endo and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 TUnknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ should be 1 Yes 2 No 3 Probably 4 Vunknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe P-Inon. death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate by 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient P 28a. Date of Injury (Month, Day Year) 27. Manper of Death completely filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertified 29c. License number MO 005 P19717 30. Name and address of person who competed cause of death (Item 2004 July e, Print) 266 22 Street, Baltimore, Md South Green 32. Registrar's Sig 31. Date filed (Month, Day, State 1 2007 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per fth 2876 2-19-08 vt.
State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** РМ 2007 June 19. 7:00 Helen Louise Deinlein /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 17, 1924 Towson 9. Birthplace (State or Foreign Country) West Virginia 7. Age (In yrs. last birthday) 5. 2145-22×1303 **Funeral** 1 M 2 XF 214-22-7411 83 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Director Baltimore Towson Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1427 Providence Road 21286 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Castaldo Anthony Palumbo ပ Rose 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Providence Rd. Towson, Maryland 21286 <u>Mrs. Judith L. Tosti/Daughter</u> 1429 B 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Grd. 6/23/07 | Timonium, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** endo metral nonth metastatic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-transi Due to (or as a consequence of): Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) I□Yes 2☑No 9☐Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has performed2 res 2 No **Division or Vital** within 24 hours after death.

To the Funeral Director: After this certific.
completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 Øother (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a To the Funeral 6 To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and little of ertifier 30. Name and address of person who composed cause of death (Mem 23a) (Type, Print) Charles it Balto Med 2:20% 15 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

			For State Registrar	State of Marylar		epartment of H Certificate of I		d Mental Hy	/giene Reg. No.	TOOP	20038
€ 30	Physicia		Decedent's Name (First, Middle, Last, Ch	arles J. Davi	sT	r.		2. Date of D Month <b>Jur</b>	Day	, 2007	3. Time of Death  2:45pm
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of D		-	County of Death	
	Funeral		802 Tula 5. Social Security Number 6. Security 1	7. Age (In yrs.			ockvil If Under 24 Hours	Hrs. 8. Date of B	ay, Year)	9. Birth Con	pplace (State or Foreign
ķ,	Director		233-38-6799 Usual Residence of Decedent	80				Februar	y 23 <b>,</b>	1927 West	t Virginia
	land ow		10a. State 10b. County	10c. Ci	ty, Town	or Location					10d. Inside City Limits
	Mary -f sh	to	Maryland Montg	omerv		P.c	ckvi11	Δ.			1 XYes 2 ☐ No
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	deat	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	I.S.	13. Was Decedent of H		? (Specify Yes or N	10-	14. Race - Amer Black, White	rican Indian,
-0030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hylgiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	1 ☐ Never Married 2 ☐ Married 3 🌠 Widowed 4 ☐ Divorced	1 X Yes 2  No If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	Specify:	dono i nodin, otory		Specify:	White
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Ξ	and 2 alth a 27 is		George C. Davis	/ Son		64 Burkshir	e Road	Towson,	Mary	land 212	286
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	5+1		30. Name and address of person who c	ompleted cause of death (Ite	m 23a) (1	1					
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DHMH 17 Rev 1/2001

			For	State of Ma	ıryland / [				d Men	tal Hygi	ene	7 -7	22020
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	arylar show d at	ř	10a. State 10b. County		10c. City, Tow	n or Loc	cation					1	10d. Inside City Limits 1 XYes 2 No
	he M 28a-f	Director	MARYLAND N/A	:	BA	LTIN	MORE			1.0			
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ISION	Attending r death. ector: After by the fune	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of inju	ry - At home fa	rm stre		′es 2 □ No	20f I	contion (Ctro	ot and Number	or or Bura	al Route Number,
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	ospita hours ineral y filler		29a. Certifier 1 Certifying Phy	vsician: To the best of	f my knowledge	e, death	occurred at the tim	e, date and pl	lace, and o	lue to the cau	use(s) and ma	nner as s	tated.
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page.	Medical	(Check only 2 Medical Exam	iner: On the basis of and manner sta	examination an	id/or inv	estigation, in my or	pinion, death o	occurred at	the time, dal	te and place, a	and due to	the cause(s)
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	6TI		30. Name and address of person who c				Print)					J P.	
U	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	<u></u>	Ite St	われた	t moc	, mi	4	-01	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #1,perbox. 688, 6/29/07 TI
State of Maryland / Department of Health and Mental Hygiene 0 7 For State Amend 20b, perFH, G868, 6/29/07 TT Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) John Henry Elam 2. Date of Death 3. Time of Death Month **Physician** 2007 8:30p.M June 17 John Hendr <del>Blam</del> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 4727 Wrenwood Ave | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 1 1 1 8 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 15 Months 1XM 2□ F NC 91 Director 238-12-2416 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s ---- any injury or other traumatic event. The Maryland once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Y Yes 2 □ No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21207 U.S.A. 4727 Wrenwood Ave 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 XNo Specify: þ Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Amalgamated Elementary/Secondary (0-12) College (1-4or 5+) 2yrs Presser 12th grade Textile & Clothing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harriett Randolph ပ Hendry Elam 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21212 4727 Wrenwood Ave, Baltimore, Md Kathleen Branch-Daughter Date Ukn 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/28/2007 4 Donation 5 ☐ Other (Specify) Baltimore, Md Crematory Inc Metro ature of Funeral Service Lic 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 var11. Enter the disease, or compleations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metactatic **Physician** colon months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): physician at the burial Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death atter for u 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) 9 Unknown been signed by ti should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 ■ Onknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy certificate ha perform 2 No To the Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ို this 28a. Date of Injury (Month, Day Year) unerai 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Flural Floute Number, City or Town, State) determined 4 Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Me MOION HOSPI 101 31. Date filed (Month, Day, Year) Registrar's Signature State JUN 2 1 2007 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death JUNE Vear Physician 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHOCKTRAUMA CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Vinder) Min. April 2, 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) **Funeral** Year) - 1948 212-50-0502 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2☐ No Director Maryland Howard Laurel 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code by Funeral 10737 Scaggsville Road USA 14. Race - American Indian, 20723 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. unt: If Item 27 Is marked other than "natural", or Ite 1 ☐ Never Married 2 ☐ Married 1.□Yes 2□ No It¥Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Project Manager Commercial Flooring Item 27 Is marked other other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry J. Flanagan Helen Geduldia ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 South Oak Cliff Ct., Mt. Airy, Maryland 21771 Wife Patricia U. Flanagan 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of I Important: If Its any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 5 ☐ Other (Specify) Lorraine Park Cem. 06/22/2007 Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Witzke Funeral Home, Inc. 5555 Twin Knolls Road, Columbia, Maryland 21045 23a. Part1. Errier the disease, or complications that consed the shock, or heart failure. In only one cause on each line sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Gram regative bacterenia **Physician** /Medical Due to (or as a o mequence of): Examiner Necrotizing Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trai Due to (or as a consequence of): Completed by Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the at d be detached fo 5 Other (specify) ☐Yes 2☐No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HEDATINO CITY HOSIS 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has t rector, page 2 s autopsy perform director, 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2[7 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 2 Natural (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending Physician: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Hospital

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

GREENE ST. DAHTIMUNE OTA

29d. Date signed (Month, Day, Year)

	1	For State Registrer	te of Maryland /	Department of H  Certificate of L		fental Hygie		2.0042
Physician /Medical	1	. Decedent's Name (First, Middle, Last) Lillian	Fr	ied		2. Date of Death Month June	Day Year 17 2007	3. Time of Death
Examiner Funeral Director		. Social Security Number 6. Sex 1 M 25	7. Age (In yrs. last	ring Colu	Location of Death  Mb'A  If Under 24 Hrs.  Hours Min.	8. Date of Birth (Month, Day, Ye March 7,	4c. County of Death Howar 9. Birth Cou 1911 New	A
aryland Bhow		Jsual Residence of Decedent  Oa. State 10b. County	10c. City, To	own or Location	-			10d. Inside City Limits 1 ☐ Yes 2 No
after death with the Maryland after death with the Maryland riteme 23e or 28e-f show plant must be notified at Euneral Director	DILECTO	Maryland Howard  Oe. Street and Number  7110 Minstrel Way ;	#320B	Columbia 101. Zip Code 2104	5	10g.	. Citizen of What Cou	
d within 72 hours after death of theme 23 or them from theme 23 or theme 23 or theme 23 or theme 23 or theme 24 or theme 25 or theme 25 or theme 25 or theme 25 or the	y runera	1. Marital Status 12. Wa Am 1 Never Married 2 Married 1 If Y	s Decedent Ever in U.S. ned Forces?  Yes 21 No es. Give	13. Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	, etc.
s 1 end 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. If Health and Mental Hygiene. Other treumstic event, the Madical Exeminar must be notified at To Re Commissed by Funeral Director	ubleted p	15. Decedent's Education (Specify only highest grade comp	lege (1-4or 5+)	Sa. Decedent's Usual Occupi (Give kind of work done of life. DO NOT use retired	ation during most of work )	ing	b. Kind of Business/li	ite
be filed withintal Hygiene. od other ther event, Irain	e a	7. Father's Name (First, Middle, Last)	4	Owner		e (First, Middle, Ma	Turniture  iden Sumame)	
d 2 should be flie th and Mental Hy 77 is marked oth treumatic event To Re	0	Charles Cottlieb  19a. Informant's Name/Relationship (Type, Prin		9b. Mailing Address (Street a	and Number or Run			
permit. Pages 1 end 2 sh Depertment of Health and Important: If Item 27 ierr eny injury or other treums once.	7:	Jeanne Green (Daught  Oa. Method of Disposition  1	20b. Place ceme	8446 King's M of Disposition (Name of etery, crematory or other place  Crematory	e) i	Date 20	a, MD 2104 c. Location · City or 1 Catonsville	own, State
permit. P Depertme Importan eny injur		21. Signature of Juneral Service Consee	2 Co	Witzke Full 5555 Twin		The second secon		
Physician /Medical		resulting in death)	that caused the death. Do no each line.	artery	g, such as cardiac			Approximate Interval Between Onset and Death
tificate be executed by a physician and as the burial-transit by a physician Examiner	X	Sequentially list conditions, f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	due to (or as a consequence	ce of):				
death cer e ettendir id for use		in the past 12 months?	es, outcome of pregnancy Live birth 2 Fetal dea Pregnant at time of death Unknown		NI	A	23d. Date of deliment	very Day Year
	o Dá	Part II. Other significant conditions contributin	ng to death but not resultin	g in the underlying cause give	en in Part I.	23e. Did tobac	cco use contribute to	
The law ete has b	Complete	Type I Diab	etes M	rellitus		24a. Was an autopsy performe	prior to c	opsy findings available ompletion of cause of
Attending Physician: The la rodath. sctor: After this certificate ha by the tuneral director, page 2	0	25. Was case referred to medical examiner? 1	1   Inpatient 2   ER/	b. Time of 28c. Injury Work	er: 4 ☐ Nursing Ho	th Check only one) ome 5 Residence 28d. Describe how	_	Assiste Living
25 5 25 00 C	Certific	3 Suicide 6 Could not be determined 28e	building, etc. (Specify)	, farm, street, factory, office		City or Town, \$		
Hosp 24 hou Fund stely fi	Medical	(Check only 2 Medical Examiner: Or one)	to the best of my knowled the basis of examination d manner stated.	dge, death occurred at the this and/or investigation, in my o	pinion, death occur	red at the time, date	and place, and due	to the cause(s)
of the of the omple	Σ	29b. Signature and title of certifier		_	o mamboi			, Day, rear)
To the within To the comple	2	29b. Signature and title of centrier  30. Name and address of person who complete	V~	$n \cdot D \mid 7$				8,2007 mp2104

Registrar DHMH 17 Rev 1/2001

State

**ORIGINAL** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

hatten

32. Registrar's Signature

Marie

31. Date filed (Month, Day, Year)

6701 N. Chades St., Rattimore Md

DHMH 17 Rev 1/2001

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2007 Physician June 18, 5:47 A M Agnes Weatherston Goldstein /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6403 Maiden Lane Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) March 20, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□ M 2∰ F Days Hours 579-62-9868 89 Yrs. 1918 Canada **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6403 Maiden Lane 20817 Canada Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager British Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Wood Agnes Scott ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6403 Maiden Lane, Bethesda, MD 20817 Earl Goldstein/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Crowns VIIIe Veterans 20c. Location - City or Town, State 20a. Method of Disposition June 20 1 Burial 2 □ Cremation 3 □ Removal from State 2007 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 22 Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 21. Signature of Funeral Service Licensee M01346 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Heart Failure Years /Medical Due to (or as a consequence of): **Examiner** Alzheimer's Dementia Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed as the burial-tran and Due to (or as a consequence of) been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? 1 Yes 24 No 1 ☐ Yes 2 ☐ No Certification: To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death 6 Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled i 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division or Vital Records, P.O. Box 68760

2

Medical

(Check only one)

29b. Signature and title of certifier

Sang-Kyune Lee, M.D. 15201 Shady Grove Rd., #202, Rockville, MD 20850 31. Date filed (Month, Day, Year) State JUN 2 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0044513

29d. Date signed (Month, Day, Year)

June 18, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** 200 CUF /Medical 4c. County of Death Examiner lumbia toward 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 9. Birthplace Country) 6. Sex 7. Age (In yrs. last birthday) (State or Foreign **Funeral** 214-30-7016 1□M 2**X**F Months Days Hours Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 Mes 2 No towar Funeral Director 10e. Street and Number 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner once. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Black þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) tician Father's Name (First, Middle, Last) Be ဂ္ (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3004 Fallstat Batto. 20b. Place of Disposition (Name of cemetery, crematory on other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Fune all ervice Licensee 23a. Part1. Enter de diseas shock, or heart failure. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated accounts) Examiner so the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated event resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 □ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4. Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsv performed certificate 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 Natural within 24 hours arter co...

To the Funeral Director: Aftr 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of ceptifies 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM! 1. per PHYS. C869.7/18/07 US
State of Maryland Department of Health and Mental Hygiene State Registrar Amend #8,perFH,g871, 9/6/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Eleanor Henderson Day 0519A M Month Year **Physician** 0 Henderson 2007 one lenora /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SAINT Agnes Healthcare If Under 1 Year | If Under 24 Hrs. | 8. [ SAL 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2**½** F 64 MD Director 1/5/1943 214-44-4285 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f shov edical Examiner must be notified at 1 ☐Yes 2 ☐ No Director NA Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 2427 West Lanvale Street U.S.A. Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-lf Yes, specity Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No
If Yes, Give X
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: Completed by 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Medical than the M ith and Mental Hygiene.
27 Is marked other than retraumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Various Jobs 12th grade Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Eliza W. Carter Howard N. Henson Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Department of Health Important: If item 27 any Injury or other tr 21207 Howard N. Henson Jr.-Brother 3711 Ferndale Ave, Baltimore, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) King Memorial Park 6/23/07 |Randallstown, Md Signature of Funeral Service Licenses 22. Name and Address of Facility
March F/H West y sug MA 4300 Wabash Ave, Baltimore, Md 21215 28a. Pa 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final see e or condition raditing in death) Due to (or as a consequence of): **Physician** /Medical **Examiner** Sequentially list conditions, if an , leadin , to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be execute burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Hendersor the IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 month Month Year 4□Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 res 2 No Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 R/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CANTON AVENUE BALTIMORE, MD 21229 MCGANN 26AN 32. Registrar's Signature State Registrar

Examiner The law requires that the death certificate be executed Records, P.O. Box 68760, Division or Vital To the

physician a s the burialattending pl signed by the a certificate has been s rector, page 2 should Hospital or Attending Physician: director After this funeral death. within 24 hours after death

To the Funeral Director:
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**Funeral** 

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**Physician** 

/Medical

0 permit. Page Department of Important: If any Injury or once.

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

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31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Place & Shimore MD 2/222

MOHAMMAD TARIMD 23 SHIPPING Place & Shimore MD 2/222 TADIMO 32 Registrar's Signature



D0021859

29d. Date signed (Month, Day, Year) 6.21.07.

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>007</u> **Physician** DANTEL THOMAS HART June 16, 10:30PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Sinai Hospital Baltimore City 8. Date of Birth (Month, Day, Year) Mar 17, 19 7. Age (In vrs. last birthday) **Funeral** If Under 2 Hours Birthplace (State or Foreigr Country) Days Months 1**X** M 2□ F Director 216-18-4107 82 1925 Maryland Usual Residence of Decedent 10a, State 10c. City. Town or Location 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at N/A 1 Yes 2 No Maryland Directo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 740 Poplar Grove Street 23a 21216 USA Funeral "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black White etc. 52 <sub>1 □ Yes 2</sub> No 1 Yes 2 No If Yes, Give Year or Dates: 150-1 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Timekeeper Steel Manufacturer 2 should be filed vand Mental Hygie is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Hart မှ Lillian (Unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum Enilie K. DeMillo (Pers. Rep.) 553 Brook Road, Towson, Maryland 21286 20a. Method of Disposition 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 6/20/2007 | Baltimore, Maryland 21. Signatule of Fundal Serv Mitchell-Wiedefeld Funeral Home, Inc Martin D. Lawson 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner 180 Due to (or as a consequence of): burial-Division or Vital Records. P.O. Box 68760. physician pe Physician/Medical the ! as IF FEMALE: use 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) the a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Ullerknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy performed? certificate 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 27. Manger of Death 28a. Date of Injury 28b. Time of e Hospital or Attending Pl 24 hours after death. e Funeral Trector After the After t 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) Injury 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral C 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22. Registrar's Signature

Shoaib Hashmi, MD, 821 N. Entaw Street, Baltimore, Maryland 21201

**Physician** 

/Medical

Examiner

Director

Be Completed by Funeral

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Physician/Medical

Be Completed by

Certification: To

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29b. Signature and title of certifier

**Funeral** Director

For State Registrar						C	Certifica	ate o	f Death			Reg.	No.	JUI	{	2005
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a. Method of Disput III Burial 2 1/2 4 Donation  Signature of Europe III III Burial 2 1/2 4 Donation  Signature of Europe III III III III III III III III III I	osition  Cremation  Cremation  Committee  George  The disease, or of tailure. List of tailure. List of the committee  The disease or of tailure. List of the committee  The committee of the comm	3 □Removecity) idensee complicationly on ca a. b. c. d. 23c. l: 1 25 Ins contribut	val from S  ons that course on e  Due to (  du	caused the ach line (or as a come pointh 2 point	he death consequ consequ consequ f pregnate me of death not resu	ence of Endeath and the ence of ence o	isposition (crematory) Crema 22. Name 22. Name 85 t enter the r 3: Arr 3: Cother the underlyling the underlyling content 3: Cother content	ic pregnar (specify ng cause	ancy  26. Plac  Other  26. Plac  Other	o6/19 ty The ven s cardiac of	23e. D  24a. W  all  ph  (Check on	200 CO	23d.  23d.  23d.  23d.  23d.	Date of del Month  Contribute to death?  1   Yes	Hon 212 Ar Information of the Corobable utopsycompics 25	MD ne, P.A 286  proximate lerval Between inset and Death y y Year  cause of death y findings availagetion of cause

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Physician** /Medical Examiner

> State Registrar

30. Name and address of person who completed cause of Jeath (Item 23a) (Type, Print)

1, ). A. R. Ley C. Bonc 6761 N. Churles St. Balto. M. 2020; 31. Date filed (Month, Day,

32. Registrar's Signature

29c. License number

025205

29d. Date signed (Month, Day, Year)

June 18, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Linda Gayle Jaeger State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month Day June 19, 2007 AEGER 2118 hrs Medical Examiner c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Pulaski Hwy. & Loraine Ave. Baltimore **Baltimore County** If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Director Country) M 165 2 F М Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location 10h County CARROLL 1 Yes 2 XNo 28a-f show MY Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
natt. If Item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10e. Street and Numbe USA Funeral 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married Yes Yes 2 No specify: If Yes, Give Yeer 4 Divorced Specify: Widowed 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 WaiTRESS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRNEST KICHARD EDNEIDA C. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SYKESVILLE MO 21784 DNEIDA ERNEST Gates 5829 MCLVILLE ROAD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 2 Cremation crematory or other place) Burial 121/2007 Important: injury or oth WINFICLD, MO **Jepartment** CARROLL CREM. Donation 5 Other Specify: Signature of Funeral Service License 22. Name and Address of Facility JN ZUMBOWN FIF 4mov. Co. 12000 ELDERSBURGMO 21784 SYKESVILLE Pad i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva Physician failure. List only one cause on each line. Between Onset and /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED the attending physician ed for use as the burial Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Dav Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 ✔ Unknown g Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Yes 2 ✔ No 3 Probably 4 Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? certificate ✓ Yes 2 1 🗸 Yes the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene After this funeral dire ۵ 1 V Yes 28a. Date of Injury (Month, Day, Year) FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Pedestrian struck by auto 1 FOUND: Natural neral Director: A Yes 2 V No within 24 hours after death. Pending Jun 19, 2007 2 🗸 Accident 2113 hrs Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) Pulaski Hwy. & Loraine Ave., Baltimore, Md determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ca 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 20, 2007 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 205 Month **Physician** Jus HAYWOOD E. INGRAM, JR. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Otto Abs If Under 1 Year If Under 24 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Davs Hours 1**∑**M 2□F 67 1940 North Carolina Director 237-58-4555 Usual Residence of Decedent with the Manyland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County or 28a-f show 1 XYes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner must be notified it Director D.C. Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 809 Malcolm-X Avenue, S.E.

1. Marital Status

1 Never Married 2 Married

1 Yes 2 No If Yes, Give **USA** by Funeral 20032 Race - American Indian. Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐XNo Baltimore, Maryland 21215-0036 Specify. Specify: Black 3 Widowed 4 NDivorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Industry Construction 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruby Smith Haywood E. Ingram, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Hunter Place, S.E.,#101, Washington, DC 20020 <u> Ernest Ingram/Son</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/16/07 4 Donation 5 Dother (Specify) | Washington, DC Glenwood Cemetery 21. Signatura Juneral Service Censee 22. Name and Address of Facility Austin Royster Funeral Home 3821- 14th Street, N.W., Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Arterios **Physician** disease or condition resulting in death) /Medicai Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a ponsequence of) Examiner as the burial-transi and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 sate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2□ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1☐ Yes 21-INO To the Hospital or Attending Physician: 25. Was case referred to medical examine?

1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient P 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 TYes 2 TNo 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide within 24 hours a To the Funeral I to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier of death (Item 23a) (Type, Print) 5

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene / 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 11:50 VAM ich UCKSON 2007 /Medical UNDE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ab. City, Town, ...

Bolt Min. State of Birth (Month, Day Year)

Office Days Hours Min. (Month, Day Year)

Office Days Hours Min. (Month, Day Year) The Johns Hopkins 6. Sex Hospital 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F 35 Director 146-64-3700 N.T Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. In Exportment of Heatth and Mental Hygiene. Instruction of Heatth and Mental Hygiene. In the 23a or 28a-1 ehow eny injury or other traumatic event, the Madical Exportment must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. fnside City Limits Director PA XXYes 2 □ No York 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 1912 Patriot Street 14. Race - American Indian, Black, White, etc. 17408 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No ff Yes, Give Year or Dates: X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) 12th grade 2yrs Customer Service Verizon Wireless 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Jackson Theresa Fletcher 19a. Informant's Name/Refationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Heron Ct. Delanco, NJ 08075

20b. Place of Disposition (Name of cemetery, crematory or other place)
Heavenly Rest
Memorial Park
6/25/07
E. Hanover, N Hillary Dow-Sister 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) E. Hanover, NJ 21. Signatul, of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 23a. Pa./1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, si ock, or heart failure. List only one cause on each line. 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death Immediate Cause (Final diserse or condition resulting in death) **Physician** raecalis Bacteremin 3 weeks /Medical Due to (or as a consequence of): Examiner Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed nding physician and use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant signed by the atten I be detached for u 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 3 Probably 4 Unknown been si should b 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 to mail director, page 2 to make the funeral director. autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No မ 1 X fnpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 14. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Leung Medical Doctor les-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Johns Hopkins Haspital bealthouse St. Buttonere Laurece PHUG 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 1 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 200 Ĺ /Medical Curle 4b City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, **Examiner** \$v. بلي a nda <u>vad</u> If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) . Age (In yrs. last birthday) **Funeral** Months Days Hours Min. X M 2 F 47 215-74-8805 MD Director 01 60 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental hygiene.

If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐Yes 2 No Catonsville Director MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21228 1325 Lincoln Wood Drive Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Black ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) injury or other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) ementary/Secondary (0-12) College (1-4or 5+) State of Maryland Correctional Officer 12th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ <u>Sally Falls</u> Andrew Jackson Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Vannessa Dow-Sister 20a. Method of Disposition Catonsville, 1325 Lincoln Wood Drive, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o once. Durial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) Owings Mills, Md 6/22/07 Garrison Forest 21. Signature of Funeral Service Licensee Marchand Flores of Weility t 4300 Wabash Ave, Baltimore, Md 21215 la Ware 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** monare /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to [or as a consequence of): Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ∐ Yes 2 **⊠** No erformed? certificate 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 XER/Outpatient 3 □ DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident the within 24 hours after death To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 003681

State Registra

31. Date filed (Month, Day, Year)

MELTOW MO 32. Registrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

MD 21133

			1 - For State Registrar		epartment of Health and Certificate of Death		6001	20055
			Decedent's Name (First, Middle, Last			Reg. 2. Date of Death		3. Time of Death
	Physici /Medi		Posey Jones			June 14.	Day Year 2007	5:30 AM M
)	Examir		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of De		4c. County of Death	
			1210 Hollins Stre		Baltimore		NIA	7
	Funeral Director		5. Social Security Number 6. Si 238-36-4469	DYM 2□ F 7. Age (In yrs, last birtho	Months Days Hours M	In. 8. Date of Birth (Month, Day, Ye	ar Col	nplace (State or Foreign untry)
	boa w		Usual Residence of Decedent  10a, State 10b, County	10c. City, Town o	r Location			10d. fnside Çify Limits
	Maryla f eho	ō	md N	1A 12	a total of			1 ■ Yes 2 □ No
	or 28s	Director	10e. Street and Number	C.	10f. Zip Code	10g.	Citizen of What Cou	untry?
	death with the Maryland me 23a or 28a-f ehow rmatte radiiled at		1210 Holl	ins St.	21223	3	US	4
030	or ite	by Funeral	11. Marital Status 1 □ Newer Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armyd Forces? 1 Myes 2 □ No ff Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? if Yes, specify Cuban, Mexican, Pu 1 ☐ Yes 2 ☐ No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Amer Bfack, White Specify:	
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ם ב	il Hyging other	Be C	17. Father's Name (First, Middle, Last)	7-1/4	18. Mother's N	lame (First, Middle, Maid	den Sumame)	420
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Mar	d 2 shouth and 7 iem		19a. Informant's Name/Relationship (7	iype, Print) 196. M	ailing Address (Street and Number or	Rural Route Number, Ci	ty or Town, State, Zi	p Code)
ย์	Heali Heali tem 2 other		20a. Method of Disposition	20b. Place of Di	sposition (Name of	Date 200	. Location - City or T	2 / 2-/ 5 own. State
=	nit. Pages artment of ortent: If it injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation / ☐ Other (Specify	Hemoval from State	crematory or other place)	-22-07 (		WILLE, MD.
<u> </u>	permit. Pages 1 a Department of Hee Important: If Item eny injury or othe once.		21. Signature of Juneral Service Licent	594	22. Name and Address of Facility	270 Fred	#14700	Pass
	0 □ E • 0		220 Part // //	lications that caused the death. Do not	sary timarch t	Funeral H	one Bat	to, md. 21229
	DI		shock or lear failure. List only of immediate Cause (Final	one cause on each line.	enter the Mode of dying, such as card	liac or respiratory arrest,		Approximate Interval Between Onset and Death
<b>)</b>	Physician /Medical		disease or condition resulting in death)	a. WWW 765TW/t) Due to (or as a consequence of):	ine pulminary o	weare		
	Examiner		Sequentially list conditions	b				
. 1	ped nsit	Examiner	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
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	antifica ing ph e as th		fF FEMALE:					
	ath ce attend for us	lan/	23b. Was decedent pregnant in the past 12 months?		3 Ectopic pregnancy		23d. Date of deliv	ery Day Year
<u>;</u>	the de ached	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□ Unknown	5 Other (specify)			
ָה מ	ss that gned b	by PI		ntributing to death but not resulting in th	e underlying cause given in Part f.	23e. Did tobacc	co use contribute to t	the cause of death?
5	een si	ted	failure to thris	vl		1 Nes	2 □ No 3 □ Prol	bably 4 Unknown
2	has b ge 2 st	Completed				24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
	in: Th	ပိ	25. Was case referred to medical			1 ☐ Yes 2 🖫		2□ No
	ysicia is cert direct	0 8	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	04	Home 5 Residence	6 □Other (Speci	6/1
5	ng Ph fter th ineral	on: T	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of fnjury 28b. Time (Month, Day Year) 1njur	of 28c. fnjury at	28d. Describe how in		<i>y</i> /
2	tendi leath. for: A the fu	catle	2 Accident investigation 3 Suicide 6 Could not be		M 1 ☐ Yes 2 ☐ No			
	i or At efter of Direction by	Certification:	4 Homicide determined	28e. Place of fnjury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St		al Route Number,
	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours elected than the terminal to the Funeriel Director. Here this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edlcal C	29a. Certifier (Check only one) 1 Sertifying Phy 2 17 Medical Exemi	sician: To the best of my knowledge, do iner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and pla r investigation, in my opinion, death oc	ce, and due to the cause curred at the time, date a	e(s) and manner as s and place, and due t	stated. o the cause(s)
	within To the	Me	29b. Signature and little of certifier		29c. License number		Date signed (Mahth,	
			> Malan	Ne	B 00517	3.7	06/19/20	707
	241		30. Name and address of person who co REYAZ HAQUE, MI)	ompleted cause of death (from 23a) (Type 827 LINDEN K	Print) V. PALTIMORE,	MO 21201		
	Sta		31. Date fifed (Month, Day, Year)	32. Registrar's Signature	AP a			
	Registra	ar	JUN 2 1 2007	Almora D. GOS	El.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 48 State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg, No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year & M 00 **Physician** 12 JUNE 200 ADAM /Medical 4a. F**2053** ame (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE f Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) **Funeral** Days 1**X**M 2□F Director Usual Residence of Deceder Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at 1 √es 2 No Funeral Director timore 10f. Zip Code 21223 10g. Citizen of What Country? 10e. Street and Number ns 23a or 2 must be n Baltimore ural", or Items 2 I Examiner mus 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) 7 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnam) Be 19b. Mailing Address (Street and Number or Plyral Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Tvp Baltimore, MD 21223 t of Health a 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) Department of Important: If it any Injury or conce. 3 □ Removal from State Baltimore, MD 1200H Funeral Services 21. Signature of Funeral Service Li 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATE OF COLEN, Physician ADGNOCARCINOMA WKS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): All IOL SU Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy certificate 2 **12** No 1□ Yes 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Sulcide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after

To the Funeral Dire

completely filled in b 1 🔛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number JUNE 13, 2007 -082 30. Name and address of person who completed cause of wath (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 20, 2007 ROMAINE KAPLAN JUNE 10:15 A F. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD 8. Date of Birth (Month, Day, Year) 10/5/1924 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign
Country) **Funeral** Days Months Hours 1 □ M 2 🔽 F MARYLAND 219-16-6367 82 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 ☐ Yes 2 ☐ No r than "natural", or Items 23a or 28a-f sh the Medical Examiner must be notified Director HARFORD **EDGEWOOD** MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21040 2316 ROSEWOOD DRIVE USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐ No if Yes, Give Year or Dates: 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: Specify: WHITE 3X Widowed 4 □ Divorced Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) **ENGINEERING** SECRETARY 12TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Is marked c LYDIA CATHERINE SWIGERT JOSEPH EDWARD KELLY ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If item 27 Is any injury or other trau once, 2316 ROSEWOOD DRIVE DELORES ANN CURTIAN/DAUGHTER EDGEWOOD, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MORELAND MEM. PARK 6/22/2007 HILLENDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee TOWSON, MD 21286 8521 LOCH RAVEN BLVD. Approximate Interval Between Onset and Death 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or as a consequence of): **Physician** disease or condition resulting in death) cur /Medical **Examiner** Sequentially list conditions if any, leading to immediate

Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: asn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death.

To the Funeral Director: / 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D12275 JUNE LO 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W. MACPHAIL ROLD BEL AIR, MD. DAVID DUNN 31. Date files (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** EDWARD **JAMES** KOLB JUNE 13,2007 5:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MANORCARE ROSSVILLE BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days XXM 2□ F 218-18-2193 **Director** 82 DEC. 5,1924 MARYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at M Yes 2 □ No Directo MD N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 104 ROCHESTER PLACE 21224 U.S.A Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces' 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify þ Specify: 3 Widowed 4 Divorced WHITE Year or Dates: "natural" Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SELF-EMPLOYED RETAIL of Health and Mental Hygie f item 27 is marked other t ir other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOSEPH KOLB မှ ELIZABETH BAST 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RUTH KOLB/ WIFE 104 ROCHESTER PLACE, BALTIMORE, MD. 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town. State permit. Pages ' Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW CREMATORY 6/13/07 BALTIMORE, MARYLAND 21. Signature of Fun 22 Name and Address of Facility
LILLY & ZEILER INC. FUNERAL HOME
1901 EASTERN AVENUE, BALTIMORE, MD. 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one can see on each line. Immediate Cause (Final ARBIOVAS WUNCE Physician HAZGE LEROTIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or, Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by I be detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Was a autopsy performed? 24a. Was an certificate has tirector, page 2 s 1∐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifie 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar

JUN 2 1 2007 DHMH 17 Rev 1/2001

one

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

M

201, BACK

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHETERIAL

29c. License number

D0060560

RIVER NEUR RD. HIOG, BALTIMOREIMD

29d. Date signed (Month, Day, Year)

JUNE 20, 2007

			1 - State of Ma		partment of H Certificate of L			ene 0 7	20059
	Physici /Medic		Decedent's Name (First, Middle, Last)     MARY KATHERINE HOLMES	LUNEYER	<b>LONG</b>		2. Date of Death Month June 19	Day Year	3. Time of Death  1:45P M
	Examir Funeral	ner	1 □ M 2 N F	a (In yrs. last birthd	Baltin  (ay) If Under 1 Year  Months Days	Location of Death  Wice City If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	4c. County of Dea  N/A  9. Bir	thplace (State or Foreign buntry)
	Director		Usual Residence of Decedent	90			Aug 24,	1916 Ma	ryland
	ith the Marylan or 28a-f show e notified at	ţō	10a. State 10b. County  Macyland N/A	10c. City, Town or	Baltimore	City			10d. Inside City Limits 1   Yes 2   No
	or 28s	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	ountry?
	ms 23e	Funerai	700 West 40th Street  11. Marital Status 12. Was Decedent E	Ever in U.S. 1	3. Was Decedent of Hi If Yes, specify Cuba	21211 Ispanic Origin? (Sp	ecify Yes or No-	USA 14. Race - Ame	nican Indian,
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Madical Examinar must be notified at	by	Armed Forces?  1 Never Married 2 Married  1 Yes 2 N  If Yes, Give Y  Year or Dates:	lo	If Yes, specify Cuba 1 ☐ Yes 2X No	n, Mexican, Puento Specify:	Ricán, etc.)	Black, Whit	e, etc. Mite
15-0	in 72 h	oletec	15. Decedent's Education (Specify only highest grade completed)	(G	ocedent's Usual Occupa ive kind of work done of e. DO NOT use retired	ation during most of work	ing 1	6b. Kind of Business	findustry
	1 and 2 should be filed withir Health and Mental Hygiene. em 27 is marked other than ither traumatic svent, the M	Completed	Elementary/Secondary (0-12) College (1-4or 5- 2 yrs		ecutive Sec			W.R. Grac	e Company
Maryland	d be file	Be	17. Father's Name (First, Middle, Last)  Jesse L. Holmes				e (First, Middle, M Myrtle k		
ary	2 should and Me Is mark	To	19a. Informant's Name/Relationship (Type, Print)	19b. Ma	ailing Address (Street a				Zip Code)
	is 1 and 2 of Health Item 27 I		Mr. Thomas K. Moseley, Esq	. 201	North Cha	rles Str	eet, Suit	te 708, Ba	lto., MD 212
mor			1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Dopation 5 □ Other (Specify)	cemetery, o	e Parck Ceme	e)			
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature & Funeral Service Nothsee  **Iartin D. Lawson  23a. Part. Enter the disease, or complications that caused	`	22. Name and Addres Mitchell-W	is of Facility liedefeld	funeral	Home, Inc	•
68760, 6	Physician and /Medical Examiner transit the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	arzy Arzy a consequence of):	mentia	ASE			Interval Between Onset and Death Unknown
P.O. Box 6	Attending Physician: The law requires that the death centif robath.  stor: After this certificate has been signed by the attending stor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mg/hths? 1 □ Yes 2 ☑ No 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of dei Month	ivery Day Year
rds, P	w requires that been signed b should be deta	þ	Part II. <b>Other significant conditions</b> contributing to death bu ドイクを27ミッショル	at not resulting in the	e underlying cause give	on in Part I.		acco use contribute to	the cause of death?
Division of Vital Records,	hysician: The law re his certificate has be I director, page 2 sh	Completed	Hypercholostrolenia				24a. Whas an autopsy perform	ed? prior to death?	itopsy findings available completion of cause of 2 No
Vita	s certifi director	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatier	nt 2 ☐ ER/Outpat	tient 3 DOA Othe		(Check only one	) nce 6 □Other (Spe	-41
n 0	ding Phy h. After thi funeral		27. Manner of Death  1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		of 28c. Injury	at ?	28d. Describe how		ыу)
Divisio	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined learning building, etc.	ry - At home, farm, - (Specify)	M 1 1	∕es 2 □No	281. Location (Stre City or Town,	eet and Number or Ru State)	ıral Route Number,
	ne Hospita n 24 hours ne Funeral sletely filled	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state.	examination and/or	eath occurred at the tim r investigation, in my op	e, date and place, inion, death occurr	and due to the cau ed at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
	To th To th	×	29b. Signature and the of ceptilier		29c. License		1	d. Date signed (Monti	
	6		30. Name and address of person who completed cause of de	eath (Item 23a) (Typ	nmo Doos De, Print)	59056	Balt M	0 21211	
	Sta Registr			r's Signature	and the same of th	.,		1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** June 19 2007 12:10 AM JUDY ANN LAU /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 11219 Basswood Terrace Prince George's Laurel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 3, 19 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Hours Days 1□M 2√F 60 Yrs Jan. Director 215-46-2044 Texas Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 No Director MD Prince George's Laurel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20708 USA 11219 Basswood Terrace Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2¼☐ No Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If them 27 is marked other than "ne any Injury or other traumatic event at once. Elementary/Secondary (0-12) College (1-4or 5+) 12th Office Manager Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Mann ဂ္ Mary Mamakos 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bryan Lau/Husband 11219 Basswood Terrace, Laurel, MD 20708 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 6/23/2007 Brentwood, MD 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licenses M01103 313 Talbott Avenue, Laurel, MD 23a. Part1. Enter the disease, or complications to it caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metastatic **Physician** CUNCU disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 9□Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 3 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 28a. Date of Injury (Month, Day Year) 28h Time of Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

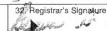
Division or Vital Records, P.O. Box 68760, To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After

> State Registrar

Medical

Donald 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

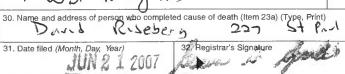


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and manner stated.

MD

Rusebern



Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

170854

Bultimon

29d. Date signed (Month, Day, Year)

21203

6/20/2007

29a. Certifier

(Check only one)

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryla	•	rtificate of		vicinarriy	Reg. No.	007	20061
le l	Physici	an.	1. Decedent's Name (First, Middle, La	st)				2. Date of De Month	eath Day	Year	3. Time of Death
	/Medic		ERWIN GEORGE					JUNE	14	2007	6:40 A M
	Examin	er	4a. Facility Name (If not institution, giv				r Lo <i>c</i> ation of Death	1		County of Death ince Geo	
٠.	Funeral	-	8813 Gramercy La 5. Social Security Number 6. 5	Sex 7. Age (In yr	s. last birthday)	Laurel If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	9. Birtho	place (State or Foreign
	Director		314-05-9278	ØM 2□F 88	Yrs.	Months Days	Hours Min.	(Month, Da March		19 Ohio	*/
	pu »		Usual Residence of Decedent  10a. State 10b. County	100 (	City, Town or Lo	eation					10d. Inside City Limits
	faryla shov	OF	MD Prince (		Laurel	oation					1 ☐ Yes 2/XINo
	the N 28a-i	Director	10e. Street and Number	seorge s   1	danci	10f. Zip Code			10g. Citiz	en of What Cou	ntry?
	3a or	iO IE	8813 Gramercy La	ne.		20	708			USA	
	ems 2	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H		pecify Yes or No o Rican, etc.)	0- 1	4. Race - Americ Black, White,	
36	s after	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divor <i>c</i> ed	1 X Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No		,			nite
Ş	hour tural	ed b	15. Decedent's E	<u> </u>	16a. De <i>c</i> e	dent's Usual Occup	ation		16b. Kin	nd of Business/In	
9200-91212	hin 72 e. an "ne Medic	Completed	(Specify only highest gra	ade completed)  College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of wor d)	king			
7	ed wit ygjene ygjene rer tha t, the	Con	12th	4		Security			-	Air For	rce
ī	be file	Be	17. Father's Name (First, Middle, Last	)			18. Mother's Nam			Surna <b>m</b> e)	
<u> </u>	hould d Mer narke natic	T <sub>o</sub>	George Labbe  19a. Informant's Name/Relationship (	Timo Print)	10h Maili	ng Address (Street		a Hallar		Town State Zin	Code)
Maryland	nd 2 s Ith an 27 Is r traur		Cheryl Labbe/Dau			Gramercy				20708	, couc,
ē,	s 1 ar of Hea item (		20a. Method of Disposition	20b	. Place of Dispo	osition (Name of matory or other place	ce)	Date	20c. Loc	cation - City or Te	own, State
<u> </u>	Page nent c int: If		1X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other ( <i>Speci</i> a	Jenoval from State		Memorial	1	5/2007	Clar	ksville	, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice	00 110		2. Name and Addre					ne, P.A.
	20 E 20		Jamecer			3 Talbot				20707	Approximato
		Se 3	23a. Part1. Fit in the disease, or comshock, or leart failure. List only	one cause on each line.	eath. Do not en	ter the mode of dyli	ng, su <i>c</i> n as cardiad	or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Renal Fa							
	Examiner			Urosepsi							
	, »·	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse							
	ecuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cCardiomy							
60,	rtificate be executed og physician and as the burial-transit		resulting in death, East	Due to (or as a cons	equence or):						
68/60,	icate physi s the b	<b>Nedical</b>		▲d							
ROX	n certific nding p use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf prec		Te			2	3d. Date of deliv	rery
	at the death cert by the attending stached for use a	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 □ Live birth 2 □ F∈ 4 □ Pregnant at time o 9 □ Unknown		⊒Ectopic pregnanc ⊒ Other (specify) _	у			Month	Day Year
r Ö	requires that the een signed by th hould be detache	Phy	9 Unknown		a a ultima la Alan u	- de de inn anna air	es is Dort I	220 Did	tobooo w	no contributo to t	the cause of death?
Š,	ires that signed to be deta	by	Part II. Other significant conditions	contributing to death but not r	esulting in the u	nderlying cause giv	ren in Pari I.				bably 4 □Unknown
Ö		eted						24a. Was			
Hecords,	sician: The law certificate has b irector, page 2 sh	Completed						auto perf	opsy formed?	prior to co death?	opsy findings available ompletion of cause of
Vital	an: T tificate tor, pa		25. Was case referred to medical				26. Place of Dea	1  Yes ath (Check only		1 ☐ Yes	2 💢 No
	nysici nis cer direct	To Be	examiner? 1 ∐ Yes 2 ∰ No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	nt 3 DOA Oth	ner: 4 Nursing H	lome 5 Res	sidence 6	6 □Other (Speci	ify)
n or	ing Pt Vfter th	uo:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor		28d. Describe	how injury	occurred	-
UIVISION	ttend death. stor: /	icati	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	e 290 Place of injuny - At	home farm st		Yes 2 ☐ No	28f Location	(Street and	d Number or Bur	al Route Number,
<u>&gt;</u>	after of Direction by	Certification:	4 ☐ Homicide determined	building, etc. (Spe	ecify)	reet, ractory, office		City or To	own, State)	)	arrioute Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, I			hysician: To the best of my k							
	in 24 the Fu the Fu	Medical	one)	miner: On the basis of exam and manner stated.	ation and/or in			urred at the time			
	With To	Σ	29b. Signature and title of certifier	0 11	•	29c. Licens			29d. Date	e signed (Month,	, Day, Year)
	111		Van	completed source of death (1)	tom 22a) /T-m-		53235	J	ine l	4, 2007	
	12+1		30. Name and address of person who Darryl Hill,			ce Avenue	, Laurel	, MD 20	707		
	Sta	ite	31. Date filed (Month, Day, Year)	32 Registrar's Sig	gnature						
	Regist	rar	JUN 2 1 20	07 Jan 1	gnature	Mary St.					

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month June Physician 2007 Leah Grace Miller 12:45 A M 21 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Westminster Dove House If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Mary Land 5. Social Security Number 8. Date of Birth (Month, Day, Year) Aug 16, 1908 6. Sex 7. Age (In vrs. last birthday **Funeral** Months Days 1□M 2□F Hours Director 217-18-3027 98 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f shov dical Examiner must be notified at 1 ☐ Yes 21 No Director MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 United States 2222 Blue Bird Dr. permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s any Injury or other traumatic event, the Medical Examiner must by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Specify Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Goldie unknown Frank Fisher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2222 Blue Bird Dr. Westminster, MD 21157 19a. Informant's Name/Relationship (Type. Print) Leah Gahn (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State S. Carroll Crematory 6/22/2007 Winfield, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Fineral Svice Lie 22. Name and Address of Facility Burrier-Queen Funeral Home and Crematory, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) AR DIAC ARRES umediate Due to (or as a consequence of): SEPSIS Sequentially list conditions, Physician/Medical Examiner if any leading to hamedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

**Physician** /Medical Examiner

Baltimore, Maryland 21215-0036

ate has I page 2 s Medical Certification: To Be funeral ours after death.

Ieral Director: A'
filled in by the fu

or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

24a. Was an autopsy performed? 1∐ Yes 🞾 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case refer	red to medical				26. Place of D	eath (Check only one)	
examiner? 1 ☐ Yes 2 云	No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	B 🗆 D0	OA Other: 4 Nursing	Home 5 Residence	6 Mother (Specify) Hospice
27. Manner of Deal 1 ☑ Natural 2 ☐ Accident	5 ☐ Pending investigation		28b. Time of Injury	м	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in	jury occurred
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined		nome, farm, street, f ify)	factor	ry, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
29a. Certifier	1 Certifying Ph	hysician: To the best of my kn	owledge, death occ	curred	d at the time, date and pla	ice, and due to the cause	(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

one)	and manner stated.
29b. Signature and tipe of ce	tifier Ocean

29c. License number 29d. Date signed (Month, Day, Year) DO061755

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

700 A Poole Rd westminster mb 2115

State Registrar

within 24 hours a

To the Funeral
completely filled To the Hospital

31. Date filed (Month, Day, Year)

HEMALATHA

(Check only



#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2007 Ruth L. McFadden June 20, 10:45A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Summit Park Nursing & Rehab Catonsville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Nov 3, 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1926 1 □ M 2 ▼ F 217-26-6384 80 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2▼ No Director Catonsville Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1 Dunmore road 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNo If Yes, Give 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: White þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Newspaper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Shaddick Mildred Unknown 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William McFadden, Husband Dunmore Road Catonsville, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: if Ite any injury or ot 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 06/21/07 Baltimore, Maryland 21. Signature of Funeral Service Licent Thomas Gregor <sup>2</sup>Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Yes 2 No 2 Accident

/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760

this

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

"natural", or Items 23a or 28a-f show edical Examiner must be notified at

er than "natur, the Medical E

if Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the M

physician and s the burial-tran as attending p been signed by the a should be detached s certificate has be lirector, page 2 s director,

within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral

0 State Registrar

Medical

29b. Signature and title of certifier

29c. License numbe

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

6 ☐ Could not be

determined

3 Suicide

29a. Certifier

4 - Homicide

516W. Rolling Bol

Certifyin Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last)
Doreatha 2. Date of Death 1 Time of Death McQueen **Physician** Jummer 4 29007 /Medical 4a. Facility Name (If not institution, give street and number)
Univ. of Maryland Medical Ctr 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 F Months Days Hours 73 Yrs 01/17/1934 Director 219-32-7537 NC Usual Residence of Decedent death with the Maryland 10a State 10c. City, Town or Location 10b. County 10d. fnside City Limits 28a-f show the Medical Examinar must be notified at MD **Baltimore** Completed by Funeral Director 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō items 23a 3919 W. Mulberry Street 21229 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after c Department of Heelth and Mental Hygiene important: if Itam 27 is marked other than "natural", or item eny injury or other treumatic event, the Medical Exerci-1 Never Married 2 Married 1 ☐ Yes 2 ★No ff Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Black Specify. Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Manager 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willie Mack Galbreath Mary Francis t9a. Informant's Name/Refationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne McQueen-Son 4106 Paran Rd., Randallstown, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State Loudon Park Cemetery 06/09/2007 Baltimore, MD 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene Funeral Services 5151 Baltimore National Pike, MD 21229 C. Greene per DVR 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between 12 hrs Immediate Cause (Final disease or condition resulting in death) Physician Cerebral Ischemia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed physicien and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) P.O. 9 Unknown ፩ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal insufficiency 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 🛣 No 1 ☐ Yes After this certification funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitaf: 1 Xfnpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred t XNatural 5 ☐ Pendina efter death.
I Director: Al investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Coufd not be 3 ☐ Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours e To the Funerel ( pelli 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29c. License number D63229 June 18, 2007 29b. Signature and title of certifier The who completed cause of death (ffem 23a) (Type, Print)
Lissauer 22 S. Greene St, Balto., Md 21201 and address of person watthew

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 2 1 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death Decedent's Name (First, Middle, Last) Time of Death Month Year **Physician** McCallister /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner paryland TIMURE breneral If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) cial Security Number (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 ▼ F 01 SC Director 214-22-3762 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 √Yes 2 No Director Baltimore NA MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with ō or items 23a U.S.A. 21224 l North Ellwood Ave Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black ò 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If tem 27 is marked other the any injury or other traumatic event, the is once. 12th grade Custodian Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Jenny Young Jessie Young 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) North Ellwood Ave, Baltimore, 21224 Md Leonard McCallisterSon 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forewt Vet 6/27/07 Owings Mills, Md 22. Name and Address of Facility
March F/H West 21 Signature of Funeral Service Licensee 4300 Wabash 21215 Baltimaore, Ave, 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immortiate Cause (Final dise se or condition resulting in death) Physiclan days -ra /Medical Due to (or as a con uence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or National or Vital Records, P.O. Box 68760, L. S. standing Physician: The law requires that the death certificate be executed after death. physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of pelson who completed cause of death (Item 23a) (Type, Print) Frahussen

DHMH 17 Rev 1/2001

State

Registrar

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31. Date filed (Month, Day, Year)

JUN 2 1 2007

32. Registrar's Signature

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ent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2007 Phys June 19,  $P^{M}$ 6:40 /Me 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Greater Baltimore Medical Center Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F 79 219-22-1688 Sept. 15, 1927 Director Md. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore Dunda l k 1 ☐ Yes 2X No Director 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 1959 Stanhope Rd. 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White \$ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Western Electric 12 yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Clarence Moss Mildred E. Love ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) James S. Moss 1803 Snyder Ave. Dundalk Md. 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition June 21 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Bayview Crematory 200**7** Baltimore 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222 in plications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. 23a. Part1. Enter the disease, or shock, or heart failure. Lis or Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** one month /Medical Due to (or as a consequence of): **Examiner** ivere one month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day Year) e Hospital or Attending Pt 24 hours after death. e Funeral Director; After the letely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALL VA DONERAN 6565 V. Charles St #303 Baltimore MD 2124 32 Registrar's Signature 31. Date filed (Month, Day, -Year) State Registrar

DHMH 17 Rev 1/2001

		Registrar  1. Decedent's Name (First, Middle,	Last)				2. Date of Dea			3. Time of Dea
sicia edic			Walter	Moore,	Sr.		Month Ju	n 16, 200	7 Year	4:00 a
mine		4a. Facility Name (If not institution,			4b. City, Town, or	Location of Death	nille		ty of Death <b>Anne Ai</b>	
			rfield Nursing Cer	nter e (In yrs. last birthd	(av) If Under 1 Year	If Under 24 Hrs.				
ral tor		219-18-7285	1 <b>X</b> □M 2□F	80 Yrs	Months   Davs	Hours Min.	8. Date of Birt (Month, Day Nov 22,	y, Year) 1 <b>92</b> 6	Cou	place (State or Fo Intry) laryland
		Usual Residence of Decedent  10a. State 10b. County		10c. City. Town o	r Location					10d. Inside City Li
	ō	,	N/A	100. Only, Town 0		klyn Park				Y Yes 2
	Directo	10e. Street and Number		<u> </u>	10f. Zip Code			10g. Citizen of	f What Cou	intry?
		209 Cedar Hill Lane				21225			U.S.A	<b>\</b> .
	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra	ace - Amer lack, White	ican Indian, , etc.
	by Fu	1 Never Married 2 Marrie  3 Widowed 4 Divorced	d 1 Y Yes 2 N If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Spec	eify: E	3lack
200	ted	15. Decedent's	Education	1946 16a. De	ecedent's Usual Occup	ation		16b. Kind of	Business/li	ndustry
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	Con	12			Managem	ent Engineer  18. Mother's Name	- /film + Middle	Maidan Cuma	200)	
9	Be	17. Father's Name (First, Middle, La	t Lawson			18. Mother's Name		ha Lawso		
Olhar Ireumalic	ဥ	19a. Informant's Name/Relationshi		19b. M	failing Address (Street	and Number or Rur	al Route Numbe	ar, City or Tow	m, State, Zi	ip Code)
		Gregory Moore Son			8387 Montgome	ery Run Road	Ellicott City	y, Marylan	d 2104	3
800	Ì	20a. Method of Disposition	2 Demousl from State	20b. Place of D cemetery,	isposition (Name of crematory or other place	ce)	Date	20c. Location		
any injury or o		1X□ Burial 2 □ Cremation 3 1 □ Donation 5 □ Other (Special Control of the Contr		1	ville Veterans C		06/22/07	Cr	ownsvil	le, Md.
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	-	- Compres	- FURUL	C/AC	1300 Eu	others Funerataw Place Ba	timore, Md	21217		Annrovimate
		23a. Part1. Enter the disease, or c shock, or heart failure. List o	complications that caused nly one cause on each lin	d the death. Do not no.	enter the mode of dyir	ng, such as cardiac	timore, Md or respiratory a	ZIZI/		Approximate Interval Betwee Onset and Dea
ian		shock, or heart failure. List o Immediate Cause (Final disease or condition	nly one cause on each life	over all	enter the mode of dyir	ng, such as cardiac	timore, Md or respiratory a	rrest,		Interval Between
		shock, or heart failure. List o	nly one cause on each life	d the death. Do not ne.	enter the mode of dyir	ng, such as cardiac	timore, Md or respiratory a	rrest,		Interval Between
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cal ner	edical	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Ener Universitying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	a. Due to (or as  b. Due to (or as  c. Due to (or as  d	a consequence of) a consequence of) a consequence of) of pregnancy 2   Fetal death	Center the mode of dying the second of the s	ng, such as cardiac	timore, Md	23d. E	Date of deli-	Interval Betwer
cal ner	edical	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant	a. Due to (or as b. Due to (or as c. Due to (or as d. 23c. If yes, outcome	a consequence of) a consequence of) a consequence of) of pregnancy 2   Fetal death	Tenter the mode of dyir	ng, such as cardiac	timore, Md	23d. E		Interval Betwee
cal ner	Physiclan/Medical	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \[ Yes 2 \] No	a. Due to (or as b. Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 \( \triangle \text{ birth} \) 4 \( \triangle \text{ Pregnant at} \) 9 \( \triangle \text{ Unknown} \)	a consequence of) a consequence of) a consequence of) of pregnancy 2   Fetal death t time of death	Tenter the mode of dyir	ng, such as cardiac	23e. Did t	23d. E	Month ontribute to	Interval Between Onset and Dead
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Z should be detached for use as the burlar-transit	Be Completed by Physiclan/Medical	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as b. Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	a consequence of) a consequence of) a consequence of) of pregnancy 2 Fetal death time of death	Tenter the mode of dyir  3 DEctopic pregnancy 5 Other (specify) he underlying cause giv	y yen in Part I.  26. Place of Dea	23e. Did t 1 1 24a. Was auto perfo 1 Yes	23d. E No obacco use co Yes 2 □ No an psy primed? 2 □ No	ontribute to  3  Pro  b. Were au prior to o death? 1  Yes	Interval Battwer Onset and Dea
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #2, perMD, g869, 7/24/07 TT Certificate of Death Reg. No. 2. Date of Death May 5, 2007 Month Day 7 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Mattison Milltory ठेउ /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 8578 www. Examiner Howard Columbia FLO Duncehou If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 11, 1921 9. Birthplace (State or Foreign Country) Wisconsin 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1⊠M 2□F 85 Director 390-16-1735 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits "natural", or Items 23a or 28a-f show deal Examiner must be notified at 1 ☐ Yes 2 No Funeral Director MD Howard Ellicott City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8566 Horseshoe Road 21043 USA death 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: white Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 engineer electric machinery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental I int: If Item 27 is marked o Oscar Mattison Irene Higbee P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Marks/daughter 8566 Horseshoe Road Ellicott City, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If Ite any injury or ot once, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Signature of Euneral Service License Director Baltimore, MD 21201 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. END STAGE PENENTIA Approximate Interval Between Onset and Death **Physician** Yeurs disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed burial-tran Due to (or as a consequence of): nding physician a Physician/Medical IF FEMALE use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant atter for u 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No o. 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No page 2 s autopsy perform 2 No certificate Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 5 Residence 6 Other (Specify) Hospital: Other: 4 Nursing Home 1 Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death funeral 28a Date of Injury 28b Time of 28d. Describe how injury occurred Certification: After (Month, Day Year) 5 ☐ Pending investigation To the riveryour after death.

Within 24 hours after death.

To the Funeral Director: Aft 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ö 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier oleted cause of death (Item 23a) (Type, Print) Ellengemo 21075 be 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2 2007 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3:45 P M **Physician** 2007 June 14 LOUISE HUDGINS MCNALLY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Laurel 3302 Sudlersville S. If Under 1 Year Months Days Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🛛 F Washington, DC 1931 3, 75 Aug. 577-44-5351 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Laurel Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 20724 3302 Sudlersville, S. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) Laurel College (1-4or 5+) Elementary/Secondary (0-12) Presbyterian Church Choir Director 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grace Allison Ronald Hudgins ဨ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Laurel, MD 3302 Sudlersville S. Francis R. McNally/Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 6/19/2007 Brentwood, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of FacilityDonaldson Funeral Home, P.A. 21 Signature of Funeral Service Licensee M01103 313 Talbott Avenue, Laurel, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only use cause on each line.

Immediate on se (Final disease or condition resulting in death)

a. Cerebral Thrombosis Approximate Interval Between Onset and Death Minutes **Physician** /Medical Due to (or as a consequence of): Examiner Days Metastatic Adenocarcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physician and thed for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4\D\Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ※ No 24a. Was an autopsy performed? Yes 242 No has 1∐ Yes this certificate the Hospital or Attending Physician: 26. Place of Death (Check only one, Be 25. Was case referred to medical examiner? Other: 4 ☐ Nursing Home 5 💆 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐XNo 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1 XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29 License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20707 321 Prince George Street, Laurel, MD William A. Warren 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Robert C. Milligan  $\mathbf{A}^{\mathsf{M}}$ June 17 2007 1:00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Mariner Healthcare of Laurel Laurel Prince George's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 □ F 80 **Director** Dec. 30 1926 216-22-0396 New Jersey Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dicai Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo MD Prince George's Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 14300 Old Gunpowder Road 20707 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examine once. 1XXYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: White <u>ک</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Owner Golf Course 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Spencer Milligan Grace Elizabeth Carels 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas S. Milligan /Son 14304 Old Gunpowder Road, Laurel, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) West Arundel Crem. 6/20/2007 Odenton, MD 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licenses M01103 313 Talbott Avenue, Laurel, MD 23a. Part 1 Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia weeks /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hypertensive Cardiovascular Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No Cerebrovascular Accident 24a. Was an autopsy performed? Yes 212 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 41 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ို 2 □ FR/Outpatient 3 □ DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 1X Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation after death 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 🗡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сотторетел (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier June 19, 2007 D23181 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 704 Gorman Avenue, # T-1 Laurel, MD 20707 R.G. Bhojraj, MD

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Saltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician Month June MAIER Emilie 2007 10 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner General Howa Howard County Colimbia If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Min. March 2) 9. Birthplace (State or Foreign Country)
New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** <sup>Year)</sup> 1920 Months 1 M 2 F Director 125-03-1497 87 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State New a or 28a-f sh 1 ☐ Yes 2 No Director Middlesex South Plainfield Jersey 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with in nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or:
Iny or other traumatic event, the Medical Examiner must be not or other traumatic event. 07080 U.S.A. 1 Bobing Court by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 200 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Hunold Louis Link ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If Item 27 is any Injury or other trau once. 9116 Goldamber Garth Columbia, Maryland 21045 Richard Maier (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory 6-18-2007 Catonsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, MD 21045 23a. Part I. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Septic Shock Preumania. **Physician** /Medical Due to (r as a consequence of) Preuninic **Examiner** respirator Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician as Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No ate has page 2 s autopsy performed 2₫No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 24 hours after death.

e Funeral Director: After thi letely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ٥ MD

Registrar DHMH 17 Rev 1/2001

State

Calland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(HAWLA

JUN 2 1

2007

31. Date filed (Month, Day, Year)

14300

32 Registrar's Signature

DUU53709

tex lan

Bowie MD 20715

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Moore reorgina 4a. Facility Name (Mnot institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A BALTIMORE FUTURE CARE-HOMEWOOD If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex 1 M 2XXF SOUTH CAROLINA 88 SEPT 15 1918 215-22-8780 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10b. County 10a. State 1 XYes 2 No Director BALTIMORE MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 2 N SMALLWOOD STREET 21223 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Specify: BLACK þ 3xEXWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FOOD & HEALTH FOOD SERVICES 8th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ို JOSEPH MILIDGE BESSIE MILIDGE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eva Cunningham/Step Daughter 1100 Fairmount Ave, Phila. Pa., 19123 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) MT ZION CEMETERY 06-18-07 LANSDOWNE, MARYLAND 22. Name and Address of Facility WILLIAM C BROWN 21. Sans ure of Funeral Service Light COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 234. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 1∐ Yes 2 **N**0 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ⋈ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 1 No P 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 🗷 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Box 68760, P.O. **Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

"natural", or Items 23a or 28a-f show idical Examiner must be notified at

and 2 should be filed within 72 hours after death eath and Mental Hygiene.

in 21's marked other than "natural", or Items 23, me 71's marked other than "natural", or Items 23, me traumatic event, the Medical Examiner must

permit. Pages 1 and 2.
Department of Health al
Important: If item 27 Is
any Injury or other trau

Physician /Medical

Examiner

attending physician and for use as the burial-transit

signed by the aid be detached f

has l certificate

After this of funeral dire

Baltimore, Maryland 21215-0036

the death certificate be execu Division or Vital Records, within 24 hours after death.

To the Funeral Director: completely filled in by the f

> State Registrar

DHMH 17 Rev 1/2001

Medical

31. Date filed (Month, Day, Year) JUN 2 1 2007

29b. Signature and title of certifier

SANDHU

4 Homicide

(Check only one)

29a. Certifier



PHYSICIAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MA

BALTIMIRE

1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

57, BALTIMORE, MD 21223

State of Maryland / Department of Health and Mental Hygiene 2007 2007 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month 0936 hrs **Medical Examiner** LESTER McCREA June 13, 2007 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Bon Secours Hospital Baltimore N/A 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8, Date of Birth (MM/DD/YYYY) 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Davs Hours Director Country) MARYLAND 1X X M 2 F 214-60-2704 59 Yrs 05/05/1948 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XXYes 2 No notified at once. BALTIMORE MARYLAND Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3045 HARLEM AVENUE Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 XXNever Married 2 Married Yes 2 X No 3 Widowed f Yes, Give Year Yes 2 X No specify: Specify: BLACK other than "natural", the Me ical Examiner 4 Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 hours Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 uit. Pages 1 and 2 should be filed within artment of Health and Mental Hygiene. ortant: If item 27 is marked other than ry or other traumatic event, the Me lic SELF HANDYMAN unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LESTER McCRAE SR MARY E SMITH 19a. Informant's Name/Relationship (Type, Print) (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deseria Harcum/Cousin 1210 Whitelock St., Baltimore, Maryland 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c, Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State MT ZION CEMETERY 06-22-07 LANSDOWNE, MARYLAND Other Specify Donation 5 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. ignature of Funeral Service Licensee 206 W NORTH AVENUE Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and Wedlest Death Immediate Cause (Final disease Acute alcohol intoxication Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical , the attending physician hed for use as the burial -XUNPENDED AMENDED 27,28a-f, perME, g868, 6/27/07 TT Box 68760 23d. Date of delivery IF FEMALE 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o signed be deta ģ Records, P. 1 Yes 2 V No 3 Probably 4 Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has 2 sl death? performed? ✓ Yes 2 1 🗸 Yes 2 No certificate the Hospital or Attending Physician: hin 24 hours after death. 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other<sub>4</sub> Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 this 1 🗸 Yes No 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury Certification: 1 Natural Director: d in by the f Yes 2 X No Pending unk FND 6/13/2007 unk 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City in 24 hou. The Funeral Div. 3 6 X Could not be Suicide or Town, State) determined (Specify) unk 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only the 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) inature and title of certife 29h O.C.M.E. June 14, 2007 (12 Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Raistrar's Signature 31. Date filed (Month, Day, Year) State

ORIGINAL

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Evelyn Henrietta Nelson 18, 2007 June 11:50 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Genises Health Care Waldorf Charles 8. Date of Birth (Month, Day, Year) May 18, 1918 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 M 2 X Months Days Hours New Castle, Pa 162 18 3113 89 Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 23a or 28a-f show any fujury or other traumatic event, the Medical Examiner must be notified at any hujury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4140 Old Washington Road 20602 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, GiveA Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ 3 Widowed 4 Divorced Specify. White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Own Home 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carl C. Lockard Daisy Bowen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William D. Nelson (husband) 4212 Carrage Drive, Temple Hills, MD 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial ②XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory June 19, 2007 Clinton, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signature of Juneral Service Licensee Alexandria Ferry Road, Clinton, MD 20735 23a. Part1. Inter the diseast, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAC ARRYTHMIA **Physician** 48.C disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner DIJE BE CORUNAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physiclan and I for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) ed by the a 1 Yes 2 No 9 Unknown 9 I Inknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by TO THRIVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DEMENT 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Tosela &

M.D.

Ashvin Patel,

31. Date filed (Month, Day, Year) JUN 2 1 2007

D44436

102 Paul Mellon Court # 102, Waldorf, MD 20602

June 19, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** VOCK rainala 6:10AM 5/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical Baltimore If Under 1 Year If Under 24 Hrs.

Davs Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday 6. Sex **Funeral** Vear 1**X** M 2□ F Sept. 7, 1956 Director 215-64-9380 50 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location show 10b. County 1X Yes 2 □ No item 27 is marked other than "natural", or items 23a or 28a-f st other traumatic event, the Medical Examiner must be notified. Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2116 North Rosedale Avenue 21216 TISA Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 K Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. SpecifAfrican American à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry s 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than ' College (1-4or 5+) Elementary/Secondary (0-12) Baltimore City 12 laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Mae Nock ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Renee Hayward / Sister 2116 North Rosedale Avenue; Baltimore, Maryland 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 'Department of Himportant: If ite any injury or of once, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory June 15, 2007 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home, P.A. 22. Name and Address of Facility Signature of Funeral Service Licens 638 N. Gilmor Street; Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pheumonia days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) P.0. I □Yes 2 □ No the 9 ☐ Unknown signed by to detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown hepatitis Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 No certificate has The Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \( \text{Nursing Home} \) 2 No 1 ☐ Yes 1 Xinpatient 2 ER/Outpatient 3 DOA P 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 28a, Date of Injury 28b. Time of To the Hospital or Attending Provithin 24 hours after death.

To the Funeral Director: After it completely filled in by the funera 27. Manner of Death 28d. Describe how injury occurred Certification: Division 1. XNatural 2 Accident (Month, Ďay Year) Injury 5 | Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

State

Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

1 200

301 St. Pa

32. Registrar's Signature

Dlo4666

Place, Baltimore, Maryland 21202

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Mulson Physician alprie 15 11:45PM 2007 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Columbia 9100 Carriage House Lane 8. Date of Birth (Month, Day, Year)
Aug. 23,1933 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 XF 73 Yrs. Kentucky Director 480-36-2734 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Columbia Maryland Howard 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code ö U.S.A. 9100 Carriage House Lane 21045 or iteme 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: Specify: þ White 3 ☑ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages i and 2 should be filed win Department of Health and Mental Hygient Important: if Item 27 Ie marked other tha eny Injury or other traumatic event, Intal 2002. Self Employed Artist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Geneva King Braulio Gancy ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3515 N. 25th Street Arlington, Virginia 22207 (Son) Joseph Nelson 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 6-20-2007 22 Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licensee MOIOSU 5555 Twin Knolls Road Columbia, MD 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Long Cunter StasiTV Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner anding physicien and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by page 2 should be Yes 2 No 3 Probably 4 Unknown Anims ( 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 Yes 2 No 1 Yes 2 No After this certifical funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Medical Certification; To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending s efter death.

I Director: Aft
of in by the fun 1 Tyes 2 No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

Division of Vital Records, P.O. Box 68760, tilled in by To the Hospital o within 24 hours of To the Funeral Di

Baltimore, Maryland 21215-0036

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert 30573 (-18-07. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11065 Little Patuxent Parkway, Columbia, MD Jon Minford, 31. Date filed (Month, Day, Year) 32 Registrar's Signation

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 9868 6-22-07 vt. State of Maryland / Department of Health and Mental Hygiene | | | | 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Shontelle Pope **Physician** 1130 Jnontell 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bultimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 73 5013 Norwood Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 ☐ M 2 ☐ 🗶 Months 34 MD Director 217-84-0218 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location ai Hygiene. other than "natural" or tlems 23a or 28a-f show vent, the Medical Examiner must be notified at 10a. State 10b. County X□Yes 2□No Director Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21207 5013 Norwood Ave Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Various Jobs Clerical 12th grade 18. Mother's Name (First, Middle, Maiden Surname) traumatic event, Department of Health and Mental Himportant: If Item 27 is marked oth any Injury or other traumatic event once. 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be <u>Victoria</u> Washington James Pope 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5013 Norwood Ave, Baltimore, Md 21207 Laura Washington-Aunt 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition X Burial 2 Cremation 3 Removal from State 6/21/07 Brooklyn, Md Calvary 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
March F/H West of Funeral Service Licensee natu 23a. P. int. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Baltimore, Md 21215 Approximate Interval Between Onset and Death Immy diate Cause (Final disease or condition ulting in death) congestive Heart Failure 2 years **Physician** /Medical Due to (or as a consequence of): 34years Examiner Syndrome Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Doe to for as a consequence of Examine attending physician and for use as the bunal-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Day 5 ☐ Other (specify) signed by the a 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 1 Yes Hospital or Attending Physician: 26. Place of Death Check onl one Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No P After this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: (Month, Day Year) 1 Natural 2 Accident Injury 5 Pending investigation within 24 hours after death,

To the Funeral Director: A 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29c. License number 29b. Signature and title of certifier 2 , Med Kes-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yolanda Hendley, The Johns Hopkins Hospital Work work street Bultimore, Maryland 21287 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 1 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Melvin George June 16. 2007 6:00 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 1106 Old Joppa Road Joppa Harford If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days M 2□ F Director 220-24-8828 Usual Residence of Decedent 2, 1928 Maryland 78 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or iteme 23a or 28e-f ehow the Medical Examiner must be notified at 1 Yes 2 No Director Harford Maryland Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1106 Old Joppa Road 21085 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 StNo Specify: Specify δ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Excavating Company permit. Pages 1 end 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other end injury or other treumatic event 2028. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Melvin George Quick Sr. Lillian Elizabeth Kerr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eva L. Quick / Wife 1106 Old Joppa Road, Joppa, MD 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Union Chapel U.M. Cem. 6-21-07 Joppa, Maryland 22 Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Inneral Service Licensee 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardiomyo Physician lears /Medical Due to (or as a consequence of): Examiner oronon Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Cardiovisular disease Physicien: The law requires that the death certificate be executed noscle ue to (or as a consequence of) Box 68760, ettending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ Fibroges monor 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ۵ this hours efter death. Inerel Director: After this y filled in by the funeral di 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral ( Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) s mpletely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 0056607 June 18th, 2007 D 30. Name and address of person who completed cause of death (I em 23a) (Type, Print) 602. S. ATWOOD Rd, BELAIR MD NGELO # 205 JO, EPH

Registrar

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Month DW /Medical 4a. Facility Name (If not institution, give st 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A niversity If Under 1 Year Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Year Months Days 1 □ M 2 🔀 F Director Maryland 219-78-5827 44 Aug 6, 1962 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Kes 2 No Baltimore Directo Maryland N/A 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 21216 1631 Ruxton Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ X o If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ **X**o Specify. 2 Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MTA **Bus Driver** 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernestine Jones Johnny B. Long ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1631 Ruxton Avenue Baltimore, Maryland 21216 Ernestine Moaney Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Agremation 3 ☐ Removal from State Catonsville, Maryland 06/20/07 4 ☐ Denation 5 ☐ Other (Specify) Metro Crematory, Inc. of Furteral Service Ligensee 22. Name and Address of Facility 21. Signatu Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin Approximate Interval Between Onset and Death he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** Hemorrhage ntra Deritoneal disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Phrom bo cytopenic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed ML attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the and be detached for 5 ☐ Other (specify) ☐Yes 2☐No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes should 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 3□ DOA ۵ 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatore and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

1

30. Name and address

ampagna Year)

2007

James

Med. Center, 22 S. Greene St., Baltimore, MD 21201

MD

led case of death (Item 23a) (Type, Print)

32. Registrar's Signature

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		1	For State Registrar		State of Ma	ryiand / i		ificate of l		-	Reg. No.	UU/	20000
	Dhuaisic		1. Decedent's Name (Fi	irst, Middle, Last						2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic	al -				othy R		S 4b. City, Town, or	Location of Dea	June	14 40 COU	2007	/) / I / M
	Examin	er	4a. Facility Name (If not	: 14		B. h.		<i>V</i>	Champe	City	40.000	-	I/A
	Funeral Director		5. Social Security Numb	er 6. Se	5 p, h.l. 0 r x 7. Age M 2 x F	(In yrs. last bi		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th ly, Year) 25, 1934	9. Birthp Cour	olace (State or Foreign Oeorgia
	3		Usual Residence of Dec 10a. State 10	b. County		10c. City, Tow	n or Loca		Baltimore			1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	28a-f s	ecto	Maryland  10e. Street and Numbe		N/A			10f. Zip Code			10g. Citizen	of What Cour	ntry?
3	Milli 3a or 2 t be n	I Dir	638 Leafyda						21208			U.S	.A.
0	be fleet within 72 hours after death with the invaryation tial Hygiene.  4d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married	2 <b>□ M</b> arried	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ X If Yes, Give	- 1 50 PM (PT)	1	as Decedent of H Yes, specify Cuba Yes 2 <b>K</b> o	ispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	E	Race - Americ Black, White, cify:	
2-00-c	nours Itural"		3 ☐ Widowed 4 ☐	. Decedent's Edi	Year or Dates:	168	a. Decede	nt's Usual Occup	ation	- 12-	16b. Kind o	Business/In	dustry
017	nin /2 e. an "na Medi	Completed	(Specify of Elementary/Secondary)	only highest grad	de completed)  College (1-4or 5-	+)	(Give ki life. DO	ind of work done O NOT use retired		orking		St. Josep	h Hospital
7	be filed within stal Hygiene. Id other than "event, the Med	Con	12_				-		Nurse	ame (First, Middle	Maiden Suri	name)	
	ntal H ed oth	Be	17. Father's Name (First		mes Reid Sr				TO. Modifici o A.	ano (rijot, maais	Bertha R		
=	ges 1 and 2 should It of Health and Men If Item 27 Is marker or other traumatic	은	19a. Informant's Name	e/Relationship (7	ype. Print)	19	b. Mailing	Address (Street	and Number or I	Rural Route Numb altimore, Ma	per, City or To ryland 212	wn, State, Zij 208	p Code)
D)	Pages 1 and 2 nent of Health int: If Item 27 iry or other tra		20a. Method of Disposi	ition Cremation 3 🗆	Removal from State	20b. Place cemet		ition (Name of atory or other pla g Memorial		Date <b>06/20/07</b>	!	on - City or T Windsot	own, State Mill, Md.
Baitil	permit. Pag Department Important: any injury o		21. Signature of Funer	ral Service Liceo		Ker ()		Name and Addrese Estep	Brothers F	uneral Servic e Baltimore,	e, P. A. Md 21217	7	
1	POM		23a. Part1. Enter he shock, or he art fa	disease, or compailure. List only	plications that caused one cause on each lin	the death.	not ente	r the mode of dyi	ng, such as card	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
F	Physician		Immediate Cause (Fin disease or condition	al	a. Ca	rdiogen	ìc	Shock					Zahn
	/Medical Examiner		resulting in death)		Due to (or as	a conse allence	e of):	1.1	6.22				
- 1	\$	ē.	Sequentially list condi-	tions,	b. Due to (or as	onsequence	e of):	Intan(	turi				
N	outed Id ansit	Examiner	cause. Enter Underlyi Cause (Disease or inju- that initiated events		C								
68760,	ficate be executed physician and s the burial-transit	al Ex	resulting in death) Las		Due to (or as	a consequenc	e of):						
89	rtificate ng phy as the	Aedical	IE ECHALO:		- 1		-		_				
J. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE:  23b. Was decedent point the past 12 moint 1	onths?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal dea		Ectopic pregnand Oth <i>er (specify)</i> _	у		23d	Date of deli	very Day Year
О	ires that the de signed by the a I be detached f		Part II. Other significa	ant conditions of	ontributing to death b	ut not resulting	in the un	derlying cause gi	ven in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
rds	quires n sign uld be	d by								_ 1□	Yes 2	lo 3∏ Pro	obably 4 Unknown
000	e law requir has been si ge 2 should	Completed								24a. Wa	opsy	prior to c	topsy findings available completion of cause of
Ē.	Physician: The la r this certificate has ral director, page 2	Com								1□ Yes	formed? 2 No	death? 1 ☐ Yes	212 No
Zit?	sician certifi rector	Be	25. Was case referred examiner?		Hospital:	ent 2 □ ER/0	Outpatient	Ot Ot	hor:	Death <i>Check onl</i> g Home 5□ Re		Other (Snec	nify)
ō	g Physer this eral di	7: To	27. Manner of Death		28a. Date of Inju	ry 28t	o. Time of Injury	28c. Inju			e how injury o		
<u>io</u>	ath. or: Afte	atio	2 Accident	5 Pending investigation		y rear)	пдагу		Yes 2 No				
Division or Vital Records,	i or Atter after de Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	200. I lace of III]	ury - At home, c. (Specify)	farm, stre	eet, factory, office			(Street and Nown, State)	lumber or Ru	ıral Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifics completely filled in by the funeral director, it	Medical C	29a. Certifier 1 (Check only 2 one)	☐ Certifying Ph ☐ Medical Exa	nysician: To the best miner: On the basis of and manner st	f examination	lge, death and/or inv	n occurred at the vestigation, in my	time, date and pl opinion, death o	ace, and due to the	ne cause(s) an e, date and pl	d manner as ace, and due	stated. to the cause(s)
•	To th To th comp	Me	29b. Signature and tit	tle of certifier	DM.M	ρ		29c. Licer	se number		29d. Date s		h, Day, Year) 2067
	2		30. Name and address	sof person who		leath (Item 23	a) (Type, 1	Print)  INAL Hos	piral of	Bulhmo	t		
	St	ate	31. Date filed (Month	) ( ( )		rar's Signature							
	Regis	trar	ILIN	2 1 200	Ana	18 1	Sant						

ORIGINAL

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4:00 AM 19ั่ 2007 Mollie Reuben June 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Harmony Hall Columbia Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 ☑ M 2 ☑ F 076-12-5053 Dec. 8,1915 New York Usual Residence of Decedent 10a State 10h County 10c City Town or Location 10d. Inside City Limits 1 ☐Yes 2☐No Columbia Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21044 U.S.A. 6336 Cedar Lane 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify Specify: 3 Midowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary Health & Welfare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gussie Cohen Herman Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6942 Cumberstone Place Gainesville, VA 20155 David Reuben (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 6-20-2007 Metro Crematory Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Witzke Funeral Homes, Inc. MOIOST 5555 Twin Knolls Road Columbia, MD 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 3 days Sepsis disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2█ No 25. Was case referred to medical 26. Place of Death (Check only one)

**Physician** /Medical Examiner

Department of Important: If it any Injury or o

**Physician** 

/Medical

Examiner

Funeral

Director

ral", or Items 23a or 28a-f show Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

ant: If item 27 Is marked other than "natural", or Items 23a or?

item 27 is marked other than "natur other traumatic event, the Medical

3altimore, Maryland 21215-0036

Director

Funeral

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Physician/Medical

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Certification:

Medical

the Maryland

physician been signed by should be detact page 2 s

certificate After this funeral r death.

The law requires that the death certificate be executed or Attending Physician: within 24 hours after death To the Funeral Director: filled in by Hospital

Division or Vital Records, P.O. Box 68760

the

State Registrar 29b. Signature and title of certifier

5 ☐ Pending investigation

6 ☐ Could not be determined

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

29c. License number D43323

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Columbia, MD 21044

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

June 19, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Living

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10820 Hickory Ridge Road Abda Ali Khan

Hospital:

28a. Date of Injury (Month, Day Year)

31. Date filed (Month, Day, Year)

1 Yes 2 No

27. Manner of Death

2 Accident

3 ☐ Suicide

29a, Certifie

4 Homicide

(Check only

1 X Natural

Registrar's Signature

		1	For State Registrar	State of Marylan	d / Depa		nt of H	ealth a		ental Hy	giene 2	007	20083
			1. Decedent's Name (First, Middle, Last)							2. Date of De		Vana	3. Time of Death
	Physicia		Mona Surajdaye R	amkissoon						Month () ( <i>b</i>	20 Day	2007	12:35 p M
).	/Medic	_	4a. Facility Name (If not institution, give s			4b. City	Town, or	Location of	Death		4c. Cour	nty of Death	
	Examin	er	11.0		so tor	1	sed				Ba	Itim	2101
			5. Social Security Number 6. Sex		last birthday	* * * * * * * * * * * * * * * * * * * *	r 1 Year	If Under 2	4 Hrs.	8. Date of Bir			place (State or Foreign
	Funeral		- 10	M 200 64	Yrs.	Months	Days	Hours	Min.	(Month, Da	1,1943	Trir	nidad
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	and and		10a. State 10b. County	10c. Cit	ty, Town or L	ocation							10d. Inside City Limits
	Aary Feho	0 1	Freeport	Set	wdass								1 ☐ Yes 2 XNo
	26a-	Director	10e. Street and Number			10f. Zi	p Code				10g. Citizen o	of What Cou	ntry?
	with por	ă	44 Arena Cemetery	Street				44			Tri	nidad	
	within 72 hours after death with the Maryland ene. Then "naturel", or iteme 23a or 28a-f ehow he Modical Exactinar must be notified at	Funeral		12. Was Decedent Ever in U	15 13	Was Dece	adent of H	lispanic Orig	in? (Sne	of y Yes or No	14. F	ace - Ameri	can Indian,
	a E	un I	.,	Armed Forces?	7.5.	If Yes, sp	ecify Cuba	an, Mexican,	Puerto I	city Yes or No Rican, etc.)	В	lack, White,	etc.
2	o or	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 🗆 Yeş	2 <b>⊠</b> No	Specify:			Spe	cify: Wes	st Indian
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γ	na na	Completed	15. Decedent's Edu (Specify only highest grad		(Give	e kind of w	ork done	during most	of worki	ng			,
Z	Mithir	E G	Elementary/Secondary (0-12)	College (1-4or 5+)		maker		-7			Own H	ome	
7	lled tygie ther t		17. Father's Name (First, Middle, Last)		TIONG	Hanci		18. Mothe	r's Name	(First, Middle	, Maiden Sum		
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<u>\$</u>	Men	ဥ	Louten Rajkumar		1 11			Romil		(D 1/ 1	O'the Tar	- Ctata 7	
Maryland 21215-0036	and and ie m		19a. Informant's Name/Relationship (T)								er, City or To		
≥ _	end selth n 27		Errol Ramkissoon								, Mary		
9	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☑ F	20b.	Place of Disp cemetery, cre	osition (Na ematory or	ame of other plac			ate	20c. Location		
Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Importent: If item 27 is marked other than "naturel; or Iteme 23a or 28a-f show amy injury or other treumatic event, the Musical Examinating the rediffied at once.		4 Donation 5 Other (Specify)		. Mary	's C∈	mete	ry J	June	22,200	7 Free	port,	Trinidad
=	mit.	1	21. Signature of Funeral Service Licens	00	2	22. Name :	and Addre	ss of Faculity	ňski	Funera	al Home	. P.A	
ñ	Ped in a	1 7	1			1407	old :	Easte	rn A	venue,	Essex,	Mary	land 21221
			23a. Part1 Enter the disease, or comp shock, or heart failure. List only o	lications that caused the dea	ith. Do not er	nter the mo	de of dys	ng, such as	cardiac o	or respiratory	arrest,		Approximate Interval Between
760,	Physician //Medical Examiner physician and physician and physician and physician and physician are physician and physician are physician and physician are physician and physician are physician are physician and physician and physician are physician and physician are physician and physician and physician and physician are physician and physician and physician and physician are physician and physician and physician and physician are physician are physician and physician are physician are physician are physician and physician are p	lical Examiner	Immediate Cause (Final disease of condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		quence of):  Quence of):  quence of):  quence of):	hol is Ga	Str	ic	ulc	er			
.O. Box 68	thet the death certificate to by the attending physic detached for use as the t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fel 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	⊟Ectopic □ Other (		y			23d.	Date of deli Month	very Day Year
٥.	8 6 8	Ď	Part II. Other significant conditions co	ontributing to death but not re	sulting in the	undertying	cause gr	ven in Part I			tobacco use		the cause of death?
of Vital Records,	The law requirete has been single 2 should	Completed								per	opsy formed?	prior to death?	itopsy findings available completion of cause of
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₹	Physicien: r this certific aral director.	Be	25. Was case referred to medical examiner?	Hospital:	DE0/0	ant cl	DOA Ot	hor			sidence 6	Other /Sa-	Cuffe)
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	3		30. Name and address of person who	completed cause of death (It	em 23a) (Typ	e, Print)	11	_	~		0 11		2007
	9		Da James A. L	Welker i	1000 8	Fran	Kru	344	are '	シュイト	Balt	a my	21231
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		1 - For State Registrar Amend #5 Per	State of Marylar				Mental Hy	•	000	
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Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	V=0	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		rth ay, Year)		nplace (State or Foreign untry)
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TAU.		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the deat	th. Do not ente	er the mode of dyin	g, such as cardia	c or respiratory	arrest,		Approximate Interval Between
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/Medical Examiner	ı	resulting in death)	Due to (or as a conseq	,			_			
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death certificate be attending physicii I for use as the bu	Physician/Medica	IF FEMALE:						1		
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uires that the de signed by the a Id be detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant <i>a</i> t time of c 9□Unknown	death 5∟	Other (specify)					
that the post of t		Part II. Other significant conditions cont	ributing to death but not res	ulting in the ur	derlying cause give	en in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
quires n sign ald be	d by	MALNOUNISIN	LENT				1 🗆	Yes 2	]No 3∏Pr	obably 4 Donknown
aw requir s been si	Completed	DEMENTIA.	MUM	4			24a. Was		24b. Were au	topsy findings available
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ding Physician: The law h. After this certificate has t funeral director, page 2 s	Be C	25. Was case referred to medical examiner?				26. Place of De	ath (Check only	one)		
Physician; r this certific ral director,	10 10	1 ☐ Yes 2 ☐ No	ospital: 1 Inpatient 2		t 3□ DOA Oth	er: 4 Nursing I	dome 5□Res	idence 6	dother (Spe	city) HOSPICE
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Attending in death. ector: After by the fune	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of injury - At he	ome farm stre		Yes 2 ☐ No	28f Location	(Street and	Number or Ri	ral Route Number.
도 약 는 c	Certification:	4 ☐ Homicide determined	building, etc. (Special	fy)	set, factory, office			wn, State)		rai noute Number,
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To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the		(1-24-00				·				
To the Ho within 24 P		30. Name and address of person who cor	npleted cause of death (Iter	n 23a) (Type. I	Print) FEAN	ANDO	DELLA	man	MO	
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amend item 1 per dec 8871 9-25-07 total Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 05 Melvin Strohminger -0 Melvin Strohnminger /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Hospital Center Carroll Westminster If Under 24 Hrs. 8. Date of Birth (Month, Day. Sept 24, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Days 1 ★M 2 □ F 95 Yrs. Maryland Director 705-05-5985 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State r than "natural", or Iteme 23a or 28e-f show the Medical Examinar must be notified at 1 Tyes 2 No Director Maryland Carroll Mt. Airy 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21771 United States death v 2505 Gillis Rd. Funerai 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Tyes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married WII Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) B&O Railroad Accountant 12th or other traumatic avant, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 12 should be fi h and Mental H 7 Is marked ot Florence Sears Franklin John Strohminger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 ment of Health a ant: If Item 27 Is Robert F. Strohminger (Son) 2505 Gillis Rd. Mt. Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page Department o Important: If any injury or once. 1 ☐ Burial 2XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/20/2007 S. Carroll Crematory winfield, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Purrier Open Funeral Home and Crematory, P.A. 1212 W. Old Liberty Rd. Winfield, MD 21784 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) -STASE RENAL DISTASE FND unterson Physician /Medical Due to (or as a consequence of) MPERTENSION Examiner in & Known Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) physician Completed by Physician/Medical as the IF FEMALE for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the page 2 should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 □ No 20 No 1 Yes 1 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attanding 5 Pending investigation 1 ☐ Yes 2 ☐ No М within 24 hours after death. To the Funeral Director: A the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier completely 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 30263 X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEMORIAL AVE WESTMINSTER KHOO, 200 FRANCIS MD

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Redistrar's Signature

2007

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day 2007 Kate G. Snow June 19 10:20 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Manor Care Towson Baltimore Towson 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland **Funeral** Months Days Hours 1 □ M 2 🔽 F 217-12-3061 86 Director July 8,1920 Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Maryland nent of Health end Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7001 N. Charles Street 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo ģ Specify: 3 Widowed 4 YDivorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assistant Principal Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Tipton Gardner Stella Gardner 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 i Barbara Snow / Daughter 1935 Ramblewood Road Baltimore, Maryland 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page Department of Important: If any Injury or once. Dulaney Valley Cem. 4 Donation 5 Other (Specify) 6/22/07 Timonium, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part1. Enter the ase. If complice shock, or heart failure. It is only one caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1☐Yes 2 No 9☐Unknown Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760, within 24 hours a To the Funeral D

> 10 State Registrar

7600

29b. Signature and title of certifie

32 Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

2-0012849

29d. Date signed (Month, Day, Year)

OSLER DI. TOWSON MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 22:06 PM SOLTYSIAK 2007 MARGARET JUNE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE WHING HOPKINS BAYVIEW MEDICAL CENTER f Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Yea 6 Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Hours 1 □ M 216-24-5205 04/16 Director /1928 Pennsylvania Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 No Director Dundalk Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 USA 7403 Manchester Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify Specify: White þ 3€Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk State of Maryland 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josephine Mc Kendrick William Hayes Long ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7403 Manchester Road, Dundalk, Maryland 21222 Daughter Linda K. Riley 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition June 23 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery Dundalk, MD. 2007 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses Connelly Funeral Home Of DUndalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death day Immediate Cause (Final **Physician** Spria disease or condition resulting in death) /Medical Due to (or as a consequence of): Obstruct **Examiner** Examiner attending physician and for use as the burial-transit Physician/Medical ρ Be Completed Medical Certification: To

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending Physician: after death.

I Director: A
d in by the fu filled in by

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq		TOTMONA	19 0154	54
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2√ No 9 □ Unknown	3c. If yes, outcome pf pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	al death 3 ☐ Ectopic			23d. Date of delivery Month Day Year
Part II. Other significant conditions con	ntributing to death but not res	ulting in the underlying	g cause given in Part I.		co use contribute to the cause of death?  2 No 3 Probably 4 Unknown
				24a. Was an autopsy performed 1  Yes 2  ☑	24b. Were autopsy findings available prior to completion of cause of death?  No 1 Yes 2 No
25. Was case referred to medical examiner?			26. Place of D	eath (Check only one)	
1 ☐ Yes 2 ⊠ No	lospital: 1 ☑ Inpatient 2 ☐	ER/Outpatient 3□	DOA Other: 4 Nursing	Home 5 ☐ Residenc	e 6 □Other (Specify)
27. Manner of Death  1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, fact fy)	tory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	sician: To the best of my kniner: On the basis of examinand manner stated.				se(s) and manner as stated. e and place, and due to the cause(s)
29b. Signature and title of certifier		<	29c. License number	29d.	. Date signed (Month, Day, Year)
1	mo		RES-000	J	UNE 19, 2007

State Registrar

Year) Registrar's Signature 31. Date filed (Month)

azmin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

Morales

within 24 hours a To the Funeral I Hospital

completely

Eastern Avenue Baltimore, MD 21224

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Rea. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11:15 A M tolarchyk June 300 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Pasadena 887 E. River If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day 9. Birthplace (State or Foreign Sex 12 M 2□F Social Security Number 7. Age (In yrs. last birthday) Hours Months Days 80 ikraine Yrs. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Anne Arundel 1 ☐ Yes 2 No 10g. Citizen of What Country? 10f. Zip Code United States allaaside Dr. 7887 E 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give 11 Marital Status Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced unk. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) ellist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SIV Shchuk Otolarchyk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Vera Stolarchyk, daughter ao a Shagburk Rd. 20a. Method of Disposition 20b. Place of Disposition (Name of commetory, crematory or other place) Middle River, MD alaao Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State -19-2007 Hanover, Anatomy Gifts Registry 6 4 NDonation 5 ☐ Other (Specify) 22. Name and Arress of acility 21. Sign Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadone MD 21122 Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part1. Enter the diseas, shock, or heart fail re. or complia Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Fesidence 6 Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined

Examiner signed by the attending physician and I be detached for use as the burial-transit The law requires that the death certificate be executed Records, P.O. Box 68760, Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Physician /Medical

Physician

/Medical

Examiner

10a. State

**Funeral Director** 

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Be Completed

Examiner

Physician/Medical

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Certification:

Medical

3 ☐ Suicide

29a. Certifier

4 | Homicide

(Check only one)

**Funeral** 

Director

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Madical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

with the Maryland

State Registrar

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tiple of sertifies

MP

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Dey, Year)

D63460

IGOR GENKIN

Location (Street and Number or Rural Route Number, City or Town, State)

DR. Gil 31. Date filed (Month Da 82. Registrar's Signature

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

		1	For State of Man		artment of H ertificate of L			ne No 2007	20089
	Dharisi		Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physici: /Medic		Louis Henry Sann					6, 2007	4:00 P <sup>M</sup>
¥	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	th
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	Funeral Director		1 <b>3</b> M 2 □ F	In yrs. last birthday, 79 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Yo	9. Bl. (2) 1927 Ma	thplace (State or Foreign ountry)
			220-22-6327 Usual Residence of Decedent				June 20,	192/ Ma	LYLANG
	how how		10a. State 10b. County 1	Oc. City, Town or L	ocation				10d. Inside City Limits
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1	or 26	Dire	10e. Street and Number		10f. Zip Code			Citizen of What C	ountry?
	ath v		413 Magnolia Road		21085			ISA	
	Item	Funeral	11. Marital Status  12. Was Decedent Eve Armed Forces?  1 □ Never Married 2 ☑ Married  1 ☑ Yes 2 □ No	er in U.S. 13.	Was Decedent of Hi ff Yes, specify Cubai	spanic Origin? (Spe n, Mexican, Puerto f	city Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
2-0036	hours after death with the Maryland turet, or Items 23a or 28a-f show at Ezamerer must be rediffed at	by	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No 1 ☐ Widowed 4 ☐ Divorced 1 ☐ Wes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify:	White
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7	e.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	life.	e kind of work done d DO NOT use retired,	) most of workir			
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ا خ	d Me d Me mark matic	၉	Louis James Sann  19a. Informant's Name/Relationship (Type, Print)	19h Maili	ing Address (Street a	Margaret			Zin Codo)
Z	alth an 27 le		Sue A. Sann / Wife		Magnolia				
e,	of He of He rothe		_	20b. Place of Disponentery, cre	osition (Name of ematory or other place	g) D	ate 20	c. Location - City of	Town, State
o I	Pag ment ant: I ury o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Hilltop	Service Co	orp. 6-21	-07 To	wson, Ma	ryland
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentral Hygiene. Importants if fine 72 is marked other than "naturel", or iteme 23a or 28a-f show any injury or other treumatic event, it a Mudical Examinat must be inclined at once.		21. Signature of Funeral Service Licensee	2	2. Name and Addres MCCOMAS	Funeral He	ome, P.A.	rdon Mar	yland 21009
			23a. Part / Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	e death. Do not en					Approximate Interval Between
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	/Medical Examiner		resulting in death)  Due to (or as a c						191 119 011 119
	-xammer	_	Sequentially list conditions, b. Due to (or as a c	onencuence of					
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-	certifica nding ph		IF FEMALE:						
XOD .	death ce	lan/	23b. Was decedent pregnant 1 23c. If yes, outcome of 1 1 Live birth 2	Fetal death 3	⊒Ectopic pregnancy			23d. Date of de Month	livery Day Year
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בו כל בו	After I	ii o	27. Manner of Death  1- Natural 5 □ Pending  28a. Date of fnjury (Month, Day Y	ear) 28b. Time o	Work		8d. Describe how	injury occurred	
VISION	death death stor: / the	cat	2 Accident investigation 3 Suicide 6 Could not be datamined 28e. Pface of Injury	- At home farm st		res 2 □No	Rf   neation (Street	t and Number or E	lural Route Number,
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	to the note that the second section of the second section of the second section of the second section of the se	Medical	29a. Certifier (Check only one)  1 Cartifying Physician: To the best of reaching the part of the basis of examinar: On the basis of examinar and manner stated	amination and/or in	th occurred at the tim ovestigation, in my op	e, date and place, a inion, death occurre	and due to the caused at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	withi To th	Σ	29b. Signature and title of certifier		29c. License	number	29d.	Date signed (Mon	
'	1.1					07/	(	0/10/0	7
]	4+1			2 S. Atwo	od Road,	Bel Air,	MD 21014		
2	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's	Signature	te				

			For State Registrar	State of I	Maryland		artment of I			-	giene Reg. No.	2007	20090
*.	Physici	an	1. Decedent's Name (First, Middle,	Last)						2. Date of De		Year	3. Time of Death
1	/Medic			NRY THOM						une	11	2007	8:17 A M
	Examir	ier	4a. Facility Name (If not institution, g Laurel Region				4b. City, Town,	_	of Death			County of Death	George's
1.00	Funeral				Age (In yrs. las	st birthday)	If Under 1 Year	If Under		8. Date of Bir	th	9. Birth	place (State or Foreign
	Director		217-14-1212	1 <b>X</b> M 2□F	89	Yrs.	Months Days	Hours	Min.	(Month, Da Dec. 8			yland
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation			J1 8-11			10d. Inside City Limits
	Maryi -f sho iled a	ţ	MD Anne Ar	undel	La	urel							1 □Yes 2 No
	or 28a	Director	10e. Street and Number				10f. Zip Code				10g. Citi:	zen of What Cou	untry?
	23a c ust be	ral	3567 Ft. Meade	Road, Apt	209		20	724				USA	
36	be filed within 72 hours after death with the Maryland that Hyglene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4▼ ☐ Privorced	12. Was Decede Armed Force 1  Yes 2 If Yes, Give Year or Date	s? <b>∑</b> INo		Was Decedent of If Yes, specify Cut 1 ☐ Yes 2X No			cify Yes or No lican, etc.)		14. Race - Amer Black, White Specify: Wh:	e, etc.
21215-0036	2 hour	ted k	15. Decedent's	Education		16a. Dece	dent's Usual Occu	pation				nd of Business/I	
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Maryland	be de la	Be	17. Father's Name (First, Middle, La	st)				18. Mothe		(First, Middle	, Maiden	Surname)	
Ž	should and Men s marke umatic	은	Unknown 19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address (Stree	t and Numbi	Unkn er or Rural		er. City o	r Town. State. Z	in Cade)
∑ S	12 m		Conrad Fleck/Per		resent		A Main			aurel,		20707	,,,
altimore,	iges 1 al nt of Hea if Item or othe		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3		20b. Plac	ce of Dispo	sition (Name of matory or other pla	ice)	Da	ite	20c. Lo	cation - City or	Town, State
<u>Ĕ</u>	Pages ment of I ant: If Ite ury or of		4 □ Donation 5 □ Other (Spe		ie	t Aru	ndel Cre	m. 6	/23/2			nton, MI	
Balt	permit. Pages Department of Important: If It any Injury or once.		21. Sign <del>ature</del> of Funeral Service Lic	ensee Albook	<i>)</i> M0110		Name and Addr 13 Talbo						
			23a. Part1. Enter the disease, or co shock or heart failure. List or	mplications that caus ly one cause on each	sed the death.	Do not ent	er the mode of dy	ing, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between
	Physician .		Immediate Cause (Final disease or condition resulting in death)	a		*	ery Dise	ase					Onset and Death
	/Medical Examiner		and the second s		as a conseque Lung Ca								
		e e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D	as a conseque								
V	cuted nd ransit	Examiner	mai milialed events	c	Atrial	Fibri	llation						
8760,	be executed sician and burial-transit		resulting in death) Last	Due to (or	as a conseque	nce of):							
387	icate t physic the b	dical		d									
P.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 □ Fetal d at time of dea	leath 3□	Ectopic pregnand Other (specify)	»y			2	23d. Date of deli Month	very Day Year
٠ <u>.</u>	res that t signed by be deta		Part II. Other significant condition	contributing to death	but not resulti	ing in the ur	nderlying cause gi	ven in Part I		23e. Did t	obacco u	se contribute to	the cause of death?
rds	w requires been sign should be	d by								10	Yes 2[	□No 3□Pro	obably 4 Unknown
900	law re las bee	Completed	A.F							24a. Was		prior to c	topsy findings available ompletion of cause of
<u>e</u>										perfo 1□ Yes	rmed?	death?	2 <b>X</b> No
<u> </u>	stciar certif irector	Be c	25. Was case referred to medical examiner?	Hospital:	OFF	2/0-4	. all so lot	hor		Check onl			
ō	g Phy er this eral di	7: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of I		8b. Time of	1 JUDON	4 LI NU		e 5∐Resi 3d. Describe		G □Other (Spec y occurred	hify)
Ö	Attending Physician: r death. ector: After this certifics by the funeral director, is	atior	1 XX atural 5 ☐ Pending 2 ☐ Accident investigat		Day Year)	Injury		rk? ]Yes 2∐	No				
Division or Vital Records,	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d Zee. Place of	injury - At hom etc. (Specify)	e, farm, str	eet, factory, office		28	3f. Location ( City or To	Street and wn, State,	d Number or Ru	ral Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	Medical	29a. Certifier (Check only one)   **Check only one)  **Check only one)	Physician: To the be aminer: On the basis and manner	of examination	edge, deatl in and/or in	n occurred at the t vestigation, in my	ime, date ar opinion, dea	nd place, a ath occurre	nd due to the d at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To T Com	M	29b. Signature and title of certifier	3			29c. Licen	se number 59228				e signed <i>(Month</i>	
	20		30. Name and address of person where Elvira Pasman			, , , , ,	Print) nter Dri	ve, Sı	uite :	202,La	urel	, MD 20	707
	Sta Registr		31. Date filed (Month, Day, Year)		strar's Signatui		20 30					-	
DHN	MH 17 Rev 1/2		JUN 2 1 20	U/ Allegen	and Sign	No. of Street, or other Persons	And the second						

**ORIGINAL** 

State of Maryland / Department of Health and Manual Hygiene  For state  Certificate of Death  Department Expert Mosticularity  Lineary Maryland (Compartment of Health and Manual Hygiene  Certificate of Death  Department Expert Mosticularity  Lineary Maryland (Compartment of Health and Manual Hygiene  Certificate of Death  Department Expert Mosticularity  Lineary Maryland (Compartment of Health and Manual Hygiene  Hygien	7-04577		Please Type or Print in Black In	delible Ink. Ensure All C	opies Are Leg	jible.	
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Description Longy Themes  To specify the participation of Description  of Descript		R	Registrar	unicate of Death			7 -
Experience   Security Number		w			Month June 15, 20	Day Year 1246 hrs	
1.			4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of	of Death	4c. County of Death	
219-73-3696		в	2715 E. Monument Street	Baltimore			
Alignor   Company   Comp	Funeral					h(MM/DD/YYYY) 9. Birthplace (State or Foreign	
100 State   100	Director		219-74-3696   XX M 2 F		Aug. 7,		
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The state of the proposition of	ours af itural		or Dates:	16a. Decedent's Usual Occupation (Give	kind of work done	16b. Kind of Business/Industry	
The state of the proposition of	72 hc	lete	Elementary/Secondary (0-12) College (1-4 or 5+)			Ly Shale ilai	41.
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Physician Medical Scanning  The part   Either the disease, or complications that caused the death Do not effect the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, its only one cause of each line.  Intermediate Cause (Final disease or conditions called in the failure) and intermediate or conditions that caused the death of the part o	AD 2 shot and a 27 is matic	-		2826 Remington Road	; Richmond, Vi	rginia 23231	
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Part			failure. List only one cause on each line.		cardiac or respiratory arri	Between Onse	
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29b. Signature and title of certifier  O.C.M.E.  June 16, 2007  30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State  31. Date filed (Month, Day, Year)  32. Segistrar's Signature	30x death	ysi	1 Yes 2 No 9 Unknown 9 Unknown	o Outer (executy)			
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29b. Signature and title of certifier  O.C.M.E.  June 16, 2007  30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State  31. Date filed (Month, Day, Year)  32. Segistrar's Signature	Divi	rţţ	Suicide O A Could not be determined (Specify)		or Town,	State)	
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Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day, Year) 32. degistrar's Signature			high, mos	O.C.M.E.		June 16, 2007	
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Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2007 June 5:30A M Walter Allen Teas, Jr. 19 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 2200 Cedar Circle Drive Catonsville If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 84 454-20-3388 Director June 21,1922 Texas Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Catonsville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2200 Cedar Circle Drive 21228 U.S.A. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 Yes 2 ☐ If Yes, Give Year or Dates: 2 □ No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗵 No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Radio & Television Announcer Broadcasting is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Wolff ၉ Walter Allen Teas, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Betty Lou Teas (Wife) 2200 Cedar Circle Drive Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 6-23-2007 21. Signature of Funeral Service License 22.Name and Address of Famility Homes, Inc. 5555 Twin Knolls Road Columbia, MD 21045 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. 23a. Part1. En er the disease, in shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ameroscherotic your /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dusito for as a consequence off: the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran-Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Nonknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 1□ Yes 2□No 2□ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Man r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 ☐ Pending investigation Injury within 24 hours arter co...
To the Funeral Director: Aft 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Terrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause ordeath (Item 23a) (Type, Print)
Robert Ammluns, MD 576 North Rolling Load Suik 204 Catonsville
Maryland Registrar's Signature 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2007 1317 6 Ketrina O. Terry /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner n/a Johns Hopkins Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 2 - 7 - 1951 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 XF Country) NC 213-60-0132 56 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Funeral Director MD Pikesville Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2 should be filed within 72 hours after death with a and Mental Hygiene.

is marked other than "natural", or items 23a or a 7901 Brookford Circle, Apt F 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: African-Completed by 3 ☐Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Muriel Reid Sr. Frances Derr 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 is
any injury or other trau
once. Tanika S. Terry/ Daughter 1383 Sugarwood Circle, Essex, MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State Woodlawn Cemetery 6/23/07 Woodlawn, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Funeral Service Licens 22. Name and Address of Facility Wylie F/H P.A. of Falto. Col 9200 Liberty Rd.,Randallstown, MD 21133 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Between And Death Immediate Cause (Final VIIDIM? Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last This to for as a consequence off Examiner burial-transit Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 🗌 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 1∐ Yes 2 200 funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only offer Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t or Attending 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No iours after death.

neral Director: A
filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			Please Type or Print in Black Indelible Ink.		•	-	
			1- State of Maryland Department of He Registrar Registrar	ealth and N Death	lental Hygie Reg.	ne <sub>No.</sub> 2007	2009,
	Physicia		Decedent's Name (First, Middle, Last)  Nellie K. Vance		2. Date of Death Month	Day Year	3. Time of Death 8:44 Am
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Li	ocation of Death		4c. County of Dear	th
	Funeral		FARNKLIN Square Hospital center Rosedo 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	a Le_ If Under 24 Hrs.	8. Date of Birth	Baltin 9. Bir	oR < the control of t
	Director		183-36-3178	Hours Min.	(Month, Day, Ye March 17, 1	ear   $Cc$	ountry)
	yland ow at		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			-	10d. Inside City Limits
	e Man Ba-f sh rtified	Director	MD Baltimore Middle River				1 □ Yes 💥 No
	be filed within 72 hours after death with the Maryland Hygiene.  ad other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		10e. Street and Number 10f. Zip Code 212	220	10g.	USA	ountry?
	ems 2:	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of His Armed Forces? 15. Was Decedent of His It Yes, specify Cuban,	panic Origin? (Sp	ecify Yes or No-	14. Race - Ame Black, Whit	
30	rs after	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2√2 No	Specify:			hite
1215-0036	72 hou natura lical E	ed			ing 16b	. Kind of Business	/Industry
121	filed within 72 hours after Hygiene. other than "natural", or ite ant, the Medical Examine	Completed	Elementary/Secondary (0-12) College (1-4or 5+)  12  College (1-4or 5+)  Sales	ing medicinen		Valmart	
land 2	e filed al Hygi other vent, tl	Be Cc	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	,	
$\sim$	2 should be f n and Mental I l Is marked of raumatic eve	일	Ralph E. Lawrence		Mae Petre	<del>-</del>	
	and 2 sh lealth and m 27 Is n her traun		19a. Informant's Name/Relationship (Type. Print)  William Parker/friend  19b. Mailing Address (Street and 3728 White Pint)				Zip Code)
ore,			20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	) :	Date 200	. Location - City or	
Baitimor	permit. Pages 1 Department of H Important: If ite any Injury or ot once.		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  4 22. Name and Address		1/2007   Ba	altimore,	MD
a C	perm Depa Impo any I		Patrick Perry per DVR Connelly F Baltimore	Tuneral 1	Home of Es	ssex, 300	Mace Ave.
	Physician /Medical Examiner	Ŀ	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. 5 2 5 5 5  Due to (or as a consequence of):				Approximate Interval Between Onset and Death Z day S Z day S
	xecuted and I-transit	xamine	if any, leading to immediate  Cause (Disease or injury that initiated events  Cause (Disease or injury that initiated events				
68/60,	be exician cian puria	ώ	resulting in death) Last  Due to (or as a consequence of):  d				
.O. Box (	requires that the death certificate een signed by the attending physi nould be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □			23d. Date of de Month	livery Day Year
1	es that gned b		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	ı in Part I.		/	o the cause of death?
Records,		eted	MeTasTaTic Colon Cancer		1 Tes		robabły 4 □Unknown
итан жес	To the Hospital or Attending Physician: The law within 24 hours after dealth. To the Funeral Director: After this certificate has b completely filled in by the funeral director, page 2 si	e Completed by	25. Was case referred to medical		24a. Was an autopsy performed	death? death?	utopsy findings available completion of cause of
	nyslcia nis cert directo	To Be	examiner?  1   Yes   2   No	**	h <i>(Check only one)</i> ome 5 ☐ Residence	e 6 □Other (Spε	ecify)
วด บด	ilng Pi After th		27. Manner of Death 1 Matural 5 Pending (Month, Day Year) 28b. Time of Injury 28b. Time of Injury Work?		28d. Describe how i	njury occurred	
UNISION	Attend death ector: ,	ficati	3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office	es 2□No	28f. Location (Stree	t and Number or R	ural Route Number,
5	ital or, rs after ral Dire	Certification:		4	City or Town, S	itate)	
	Hospi 24 hou Funer etely fill	edical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated.	e, date and place, inion, death occur	and due to the caus rred at the time, date	e(s) and manner as and place, and du	s stated. e to the cause(s)
	To the within To the comple	Med	29b. Signature and title of certifier 29c. License r	number	29d.	Date signed (Mont	th, Day, Year)
				6540	9 0	6-08-	.07
	((,))		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	ap DRU	e Balt	and P da	0 21237
p 6	Sta	te	Dr. Maria Carrillo MD 9000 Franklin Squa  31. Date filed (Month, Day, Year)  JUN 2 1 2007  32. Registrar's Signature	The NIVO	-, 10 000 11	MOI IN	y -10-1
	Registr	ar	JON 4 I COOL THEN DE DE MARCO				

		1. Decedent's Name (First, Middle, Last)							<ol><li>Date of Deat Month</li></ol>	h Day	Year	3. Time	of Death
Physici /Medic		Raymond Wilson							June 5	, 200	7	6:46	AM M
Examin		4a. Facility Name (If not institution, give				, Town, or		of Death			inty of Deal		
A 48		Prince George's M				verly er 1 Year	If Under	24 Hrs. I	0. Data - ( B) 4b	Pr		George	
Funeral Director		5//-46-08/0	7. Age (In	70 Yrs.	Months		Hours	Min.	8. Date of Birth (Month, Day, Sept 16			thplace (State ountry)	unk
* #		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or L	ocation							10d. Inside	City Limits
# 3	ğ	DC		Washing	ton							1 □ Ye	es 2 No
r 28a	Director	10e. Street and Number				ip Code			10	0g. Citizen	of What Co	ountry?	
23a or 28a-f show	JE D	4017 8th Street NE					2001	17			USA		
eme E.T.	Funeral		12. Was Decedent Ever Armed Forces?	in U.Sunk 13.	Was Dec	edent of Hi			cify Yes or No- Rican, etc.)			erican Indian, te. etc.	
iene. rthan "netural", or Iteme 23a or 28a-f show Ite Medical Examinar mant by ristlified at	J. F.	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give			2 <b>V</b> No	Specify:				ecify:	black	
"netural", idical Exe	d by	3 Widowed 4 Divorced	Year or Dates:	16a Door	doot's He	ual Occupa	ation		unk	16h Kind o	of Business		unk
a dia	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	(Give	e kind of w	ual Occupa rork done d use retired	during mos	t of workin		IOD, KING C	A Dusiness	industry	
iene. r than "	E O	Elementary/Secondary (0-12)	College (1-4or 5+)										
H the	BeC	17. Father's Name (First, Middle, Last)	.IK.		u	ink	18. Mothe	er's Name	(First, Middle, M	Aaiden Sur	пате)		unk
marked o	To B												
f Health and Mer ttam 27 Is marke other traumatic		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mail	ing Addre	ss (Street a	and Numbe	er or Rural	Route Number,	City or To	wn, State, .	Zip Code)	
n 27 I		Prince George's Me					Driv		everly,		20785		
0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	1	Ob. Place of Disp cemetery, cre			(8)	Di	ate	20c. Locati	on - City or	Town, State	
ment:		4 □ Donation 5 X Other (Specify)	in state				į						
Department Important: If any injury or once.		21. Signature of Financial Service I cons ROTAL D	Nade, Direc	tor S	tate	Anato Anato nore,	omy B	öard 21201	655 W.	Balti	Lmore	Street	Ė
		23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	ications that caused the ne cause on each line.	death. Do not er	nter the mo	ode of dyin	g, such as	cardiac or	respiratory arre	est,		Approxim Interval B	Between
ysician		Immediate Cause (Final disease or condition	Pneumoni	а								Onset an	d Death
Medical		resulting in death)	Due to (or as a co	nsequence of):				,					
aminer		Sequentially list conditions,	Acquired		Defi	cienc	y Syn	drom	2				
iis	iner	ri any, leading to immediate cause. Enter Underlying	Dué to (or as a co	ന്നാരവരനാര വി).									
physicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	insequence of):	-	_	_				_		
cien	E		200 10 (0) 43 4 00										
phys the	dicai		d		_								
ding	Physician/Med	IF FEMALE:	3c. If yes, outcome of p	regnancy						23d.	. Date of de	liverv	
for afte	clar	in the past 12 months?	1 Live birth 2 ☐ 4 Pregnant at time	Fetal death 3	□Ectopic □ Other (	pregnancy specify)				250	Month	Day	Year
by the a	ysi	1 Yes 2 No 9 Unknown	9□ Unknown										
pe op	by Pi	Part II. Other significant conditions con	•	ot resulting in the	underlying	cause giv	en in Part I		23e. Did tob	oacco use	contribute t	o the cause o	of death?
n sign uld be	De De	Encephalopathy	7						1 □ Y€	s 2□N	lo 3□P	robably 4	Unknown
s been s	Completed								24a. Was a			utopsy finding completion o	
ate ha	E o								perform	ned?	death?		11 02030 01
tific or.	0	25. Was case referred to medical					26. Place	e of Death	(Check only on				
direct	To B	examiner? 1 □ Yes 2 ☑ No	lospital: 1 🗆 Inpatient	<b>2</b> €R/Outpatie	ent 3 🗆 1	Oth Oth	er: 4□Nt	ursing Hon	ne 5□Reside	ence 6	Other (Spe	ecity)	
iffer death.  Director: After this certific in by the funeral director,		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Ye	28b. Time Injury	of	28c. Injun Wor	y at k?	2	28d. Describe ho	w injury o	ccurred		
death. ctor: A	atic	2 Accident investigation			М	1 🗆	Yes 2 🗌						
i e	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (5	At home, farm, s Specify)	treet, facto	ory, office		2	28f. Location (St City or Town		umber or A	lural Route N	umber,
within 24 hours at To the Funeral D completely filled i		(Check only 2 Medical Exami	sician: To the best of m ner: On the basis of ext										e(s)
hin 24 hours a the Funeral mpletely filled	Medical	one)	and manner stated			9c. Licens						-	
To Con	-	29b. Signature and title of certifier	unk	4				10		6/		th, Day, Year 2	/
		1000				DI	00	10		-/	/ (		
	4	30. Name and address of person who co	empleted cause of death	n (Item 23a) (Type <b>ndover</b> R									

DHMH 17 Rev 1/2001

246-291430,496

07-04670 Loran Eric Walter

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

e of Maryland / Department of Health and Mental Hygiene			0 10 0	
Certificate of Death	Reg No	CUUI	the city of	1

		I- For State	•	Ċer	tificate o	f Death			- Re	g. No.	UUI	11000
Physicia	ın/	<ol> <li>Decedent's Name (First, Midd</li> </ol>							<ol><li>Date of Deat Month</li></ol>	Day Year	-	Time of Death
ledical Examii		Loran Eric W						(5 "	June 18, 2	2007		1645 hrs
		4a. Facility Name (if not instituti 2 Thistle Road	on, give street and nun	nber)		4b. City, Town Catonsvi		of Death		4c. County o	or Death e County	
-	=	5. Social Security Number	6. Sex	7. Age (In yrs. Ia	est hirthday)	If Under 1		der 24Hrs.	8. Date of Bir	th(MM/DD/YYYY		
Funeral Director		212-54-8994	1 X M 2 F	51		Months I			-	, 1955	Foreign Country	
	-	Usual Residence of Decedent	121 M 2 F	71	. Yrs	». <u> </u>			DEC 12	, 1900		, LID
а У У	a it serv	10a. State 10b. County	/	10c. City,	Town or Local	tion					100	d. Inside City Limits
· .		MD Baltin	more	Cato	onsvill	e					1	Yes 2 X No
faryland 28a-f show	g.	10e. Street and Number				10f. Zip Cod	e	_	1	0g. Citizen of Wh	at Country?	>
he M	Director	2 Thistle Rd				21228				USA		
death with the Maryland or items 23a or 28a-f she nust be notified at once		11. Marital Status		edent Ever in U.		as Decedent of			ecify Yes or No	- 14. Race		Indian, Black,
death r iten	Funeral	1 Never Married 2 X	Married Armed Fo	rces?		res, specify Cu			Rican, etc.)	White	, etc.	
after	by		ivorced If Yes, Give Year or Dates:			Yes 2 X				Specify:	White	
MD 21215-0036 2 should be filed within 72 hours after h and Mental Hygiene. 27 is marked other than "natural", o		15. Decedent's Education (Sp				nt's Usual Occ nost of working				16b. Kind of Bu	siness/Indu	stry
36 n 72 nan "lical J	Completed	Elementary/Secondary (0-12		-4 or 5+)						Donles	•	
5-0036 lled within 72 Hygiene. I other than the Medical	E	17. Father's Name (First, Middle	4		Accour	itant	18 Moth	er's Name	(First, Middle, I	Banki Maiden Surname		
al Hy sed of	Be C	John Walter	0, 2001)					e Bau				
21215-0036 Judd be filed within ?! I Mental Hygiene. marked other than ic event, the Medical	To B	19a. Informant's Name/Relation	nship (Type, Print )		19b. Mailin	g Address (S				nber, City or Tow	n, State, Zıç	Code)
and 2 should be filealth and Mental I ten 27 is marked traumatic event.	7	Ellen Sawaya/S	Significant	tOther	2 Th:	istle F	d Cat	onsvi	11e, M	21228		
ore, MD s: 1 and 2 sho of Health and If item 27 is	Ì	20a. Method of Disposition			Place of Dispo		f cemetery,		Date	20c. Location -	City or Tov	vn, State
MOFE Pages 1 ent of H it: If i		1 Burial 2 X Crematic		mi State	tro Cr	. ,	, Inc	6/2	0/07	Baltim	ore, I	MD
Baltimore, MD 21215-00°, pemit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other tinjury or other traumatic event, the Med	1	O4 Cincolnus of Francis Contin	a Licences		22	Name and Add	ress of Eacil	lity				
E P P W	99	23a. Part I. Enter the disease, of	) 0. 10	Jua DIII	29	9 Fred	n Soci erick	Rd B	of Mary altimor	e MD 21	1C. 1228	
Physician		23a. Part I. Enter the disease, of failure. List only one caus	or complications that ca se on each line.	used the death.	. Do not enter	the mode of dy	ing, such as	cardiac or	respiratory arr	est, shock, or he	art A	Approximate Interval Between Onset and
/Medical Examiner	1	Immediate Cause (Final diseas				ng multi:	de scle	rosis			_	Death
		or condition resulting in death)	Due to (or as a	consequence o	f):							
	e.	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of	f):							
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ecuted and transit	Exa	events resulting in death) Last		consequence o	t):						-	
~ - '	edical	XUNPENDED	a AMENDED -	~~~ 07.00		<b>m</b> 060	7/05/05					
760, icate be ext physician the burial -	Nedi	IF FEMALE:	#23a,1	Outcome of pred	n-f, peri	Œ,g869,	//25/0.	/TT		23d. Date of	delivery	
	an/M	23b. Was decedent pregnant in past 12 months?	the 1 Live b	irth	2 F	etal death	3 Ecto	pic pregna	ncy	Month	Day	Year
Box 687 he death certific the attending p	sician		nknown g Unkno	ant at time of de	eath 5 o	ther (Specify)						
O. By the de by the ached f	Phy	Part II. Other significant cond			esulting in the	underlying cau	se given in	Part I.	23e. Did t	obacco use contr	ibute to the	cause of death?
ires that the signed by I be detach	ξ	Bronchopneumon			3	, ,			1 Ye	s 2 No 3	Probabl	ly 4 🗸 Unknown
ords, w require s been si	Completed				_				24a. Was			sy findings available
COF law r has b	ם						_			ormed?	death?	pletion of cause of
tal Recian: The certificate ector, page		05 W	201			26.5	Place of Dear	th (Chack (		2 No 1	✓ Yes	2 No
of Vital Records, g Physician: The law requir After this certificate has been s meral director, page 2 should	Be	25. Was case referred to medic examiner?	[Hespital:	npatient 2	ER/Outpatier		Other		g Home 5	Residence 6	✓ Other: Sr	cene
n of V ling Phy. After thi funeral d	۲.	1 Yes 2 No 27. Manner of Death	28a. Date	of Injury	28b. Time of		Injury at Wo			how injury occur		
ion ceath.	tion		nding Fnd 6/	, Day,Year) 18/2007	Fnd 4:4	45 pm 1	Yes 2	ΧNο	subject	exposed to	o hot €	environment
Division tal or Attendir 15 after death. al Director: A	fica	Δ.	estigation	e of Injury - At h		-	ice building,	etc.	28f. Location (	Street and Numb	er or Rural	Route Number, City
Div	Certification:		termined (Specify)	house					2 Thist1	s <sub>tate)</sub> Le Rd. Cato	onsvill	Le, MD
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certification of Attending Physician: The law requires that the death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier (Check only) Certifying	Physician: To the bes	t of my knowled	ge, death occi	urred at the tim	e, date and	place, and	due to the cau	se(s) and manne	r as stated.	()
Fo the within Fo the	Medical	2	caminer: On the basis of and manner s		and/or investiga				it the time, date			
- 2-0	Š	29b. Signature and title of certi	fier				cense numb	er		29d. Date sign		, Day, Year)
		mas 2					.C.M.E.			June 19, 2	.007	
		30. Name and address of person				Street Bell	imoro M	D 21204	1			
			ssistant Medical E	=xaminer egistrar's Signati	111 Penn	Oueet, Dal	.inioie, M	J Z 1ZU				
St Regis	ate trar	31. Date filed (Month, Day, Yea	2007	ese A	1 6	A.						
DHMH 17 Rev 1/2		- JUN 6 1	2001		ORIGINA	AL			12 (1992)			

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2 Date of Death Time of Death June 16, 2007 Year 0150 hrs **Medical Examiner** GERALD B. WELLS 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) c. County of Death Baltimore N/A 921 Appleton St. If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Foreign Country) Days Months Hours Min. Director 212-90-6533 1 X M 2 F 43 6-8-1964 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No MD. N/A BALTIMORE 23a or 28a-f show notified at once, 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 921 APPLETON ST. 莅 21217 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, Health and Mental Hygiene. item 27 is marked other than "natural", or items traumatic event, the Medical Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 X Never Married 2 Married Yes 2 X No Divorced If Yes, Give Year Yes 2X No specify: Pages 1 and 2 should be filed within 72 hours after BLACK ð 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 -12--0-NURSING ASSISTANT HOSPITAL 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) WILLIAM WELLS of Health and Mental MINNIE THOMAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD MINNIE WELLS (MOTHER) 921 APPLETON ST. BALTIMORE, MARYLAND 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery. Date 20c. Location - City or Town, State Baltimore, X Burial crematory or other place) Crem 3 Removal from State ation tant: ARBUTUS MEMORIAL PARK 6-23-2007 BALTIMORE, MARYLAND HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. ONATHAN License 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 t I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** ure. List only one cause on each line. Between Onset and /Medical Death a. Hanging diate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Tn the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. hysician/Medical attending physician for use as the burial -UNPENDED AMENDED Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Dav Year past 12 months? Pregnant at time of death Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown g Unknown P.O. Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 ✓ No 3 Probably 4 Unknown Completed Division of Vital Records, has been s 24b. Were autopsy findings available 24a, Was an prior to completion of cause of performed? death? certificate l' ector, page Yes 2 V No 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 examiner? Other<sub>4</sub> Nursing Home 5 Residence 6 ✔ Other: Scene this Inpatient 2 ER/Outpatient 3 DOA 1 ✓ Yes No 28a. Date of Injury (Month, Day,Year) FOUND: After 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work Certification: Subject hanged self Natural FOUND: Yes 2 V No Pending Funeral Director: stely filled in by the Jun 17, 2007 0150 hrs 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 921 Appleton St., Baltimore, Md. determined (Specify) Townhouse / Rowhouse Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 2 To the I Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and fitte of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 17, 2007 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Susan Hogan MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 **OCME 2006** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 1 State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Willena 2. Date of Death Estella Wheeler **Physician** 2346 PM 200 WNE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE JOHNS BAUTMORE HUSPITAL If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🙀 F 07/02/1944° 240-74-4880 62 North Carolina Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show marked other than "natural", or Items 23a or 28a-f shor matic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director MD Capital Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 502 Hill Road 20743 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: ģ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Self Entrepreneur other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked c any Injury or other transment Willie Scott Forbes, Sr. Sallie Melvin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Leroy Wheeler - Husband 502 Hill Road; Capital Heights, Maryland 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State 06/19/2007 Artis Family Cemetery 4 Donation 5 Other (Specify) Stantonsburg, N.C. 22. Name and Address of Facility Freeman Funeral Services 4594 Beech Road; Temple Hills, Maryland 20748 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ulmonary 5 hours /Medical Due to (or as a con vuence of) Examiner 6 MONTHS Endomernal conce Sequentially list conditions, Examine lany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed use as the burial-trans and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4☐Pregnant at time of death Month Day Year 5 ☐ Other (specify) P.0. signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Natural 2 Accident 5 Pending investigation ours after death.
neral Director: A
filled in by the fu death. 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number JUNE 12 2007 RFS-000 or leted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

filed (Month, Day, Year)

JUN 2 1 2007

32. Registrar's Signature

THE JOHNS HOPKINSHOSPITAL GOON. WOLFE ST. BALTIMORE MO 21284

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Dav Month Year Physician 12:12 A<sup>M</sup> 15, 2007 June Katharine Pauline Wastler /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford 522 Thomas Run Road Rel Air If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 M 2 XF 91 Apr. 16, 1916 Maryland Director 215-07-9148 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County in then "natural", or iteme 23s or 28s-f show the Medical Examiner must be notified at 1 ∏Yes 2 TNo Director Maryland Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 522 Thomas Run Rd. 21015 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 XWidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Oil Distribution 11 Comptometer Operator 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fill ment of Health and Mental H lant: If Item 27 ie marked ott ဨ Ferdinand L.J. Ohle Elizabeth M. Sauter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1914 Thomas Run Circle, Bel Air, MD 21015 Kathleen A. Sprole/Daughter important: if item eny injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-18-07 Thurmont, Maryland Blue Ridge Cemetery ! 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 50 W. Broadway, Bel Air, Maryland 21014 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician en S disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a conse Examine physicien and the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 3 Ectopic pregnancy Month Year Day 5 Other (specify) 4□Pregnant at time of death been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part IJ. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ete has page 2 s 1 Tes certificete 1 Yes 2 □ 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 3□ DOA this After thi funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 ☑Natural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No al Director: A investigation death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours efter To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) Name and address of Terson who 1308Busing FARP 170 32 Registrar's Signature 31. Date filed (Month. Day, Year) State Coartes JUN 2 Registrar

07-04641 Scott Wheeler Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar  Certificate of Death Reg. No. 2007	JIU
Physician/	1. Decedent's Name (First, Middle,Last)  2. Date of Death Month Day Year	
Medical Examiner	NACCECT CONT. 10, 2007	<u></u>
	University Hospital Baltimore City N/A	
Funeral Director	5. Social Security Number 217-17-1198 6. Sex 1 X M 2 F 7. Age (In yrs. last birthday) 31 Yrs. If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State of Birth (MM/DD/YYYYY) 9. Birthplace (State of Birth (MM/DD/YYYY) 9. Birthplace (State of Birth (MM/DD/YYYY) 9. Birthplace (State of Birth (MM/DD/YYYYY) 9. Birthplace (State of Birth (MM/DD/YYYY) 9. Birthplace (State of Birth (MM/DD/YYYY) 9. Birthplace (State of Birth (MM/DD/YYYYY) 9. Birthplace (State of Birth (MM/DD/YYYY) 9. Birthplace (State of Birth (MM/DD/YYYYY) 9. Birthplace (State of Birth (MM/DD/YYYYY) 9. Birthplace (State of Birth (MM/DD/YYYYY) 9. Birthplace (State of Birth (MM/DD/YYYY) 9. Birthplace (State of Birth (MM/DD/YYY) 9. Birthplace (State of Birth (MM/DD/YYY) 9. Birthplace (State of Birth (MM/DD/YYY) 9. Birthplace (State of Birth	ΣΓ
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ith the Maryland 23a or 28a-f show any notified at once. al Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
with the ms 23a or be notified		ick,
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.  Int: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director		
5-0036 led within 72 hours aft Hygiene. other than "natural" the Medical Examine Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry	
21215-0036 build be filed within 72 hour Mental Hygiene. marked other than "natu ic event, the Medical Exan TO Be Completed	4 Police Officer Law Enforcement  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)	
1215 dbe files lental Hy arked o svent, th	Charles F. Wheeler Janet Wendelstedt	
MD 21 d 2 should th and Me th and Me aumatic ev	19a. Informant's Name/Relationship (Type, Print )   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   Tracy Wheeler (Wife)   652 Grain Court Millersville, Maryland 21108	- 1
nore, MD 2121.  gges I and 2 should be fil  nt of Health and Mental I  triftem 27 is marked other traumatic event, To Be	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20b. Place of Disposition (Name of cemetery, crematory or other place)	
- F W O	4 ponation 5 Other Specify: Metro Crematory 6/22/07 Baltimore, Maryl	and
	Cleant Wars M00809 Gary L. Kaufman Funeral Home @ MMP, Inc. 7250 Washington Blvd. Flkridge MD 21075  23a. Payl Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate.	e Interval
Physician /Medical xaminer	faiture. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):	nset and
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ted Insit Examiner	cause. Enter Underlying Cause (Disease or injury flat initiated events resulting in death) Last  Due to (or as a consequence of):	
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760, cate be execu physician and he burial - trr	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
ox 68' ath certiff ath certiff or use as sician	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day  4 Pregnant at time of death 5 Other (Specify)	Year
P,O, Bcs that the designed by the a detached for by Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of d	
ds, P.C equires that een signed ould be deta	1 Yes 2 No 3 Probably 4 U	available
Vital Records, lystician: The law requires this certificate has been significated, page 2 should be o Be Completed	autopsy prior to completion of c performed? death?  1 ✓ Yes 2 No 1 ✓ Yes 2	No No
fital sician: is certif lirector, Be (	25. Was case referred to medical 26.Place of Death (Check only one)  examiner?   Hospital:   Inserting   26.Place of Death (Check only one)    Other:   Number of Death (Check only one)	
Division of Vital Records, P.O Ital or Attending Physician: The law requires that the safer death and Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacertification: To Be Completed by Fertification: To Be Completed by Fertification:	27 Manner of Death 23a Date of Injury 28h Time of Injury 28h Injury at Work 2 28d Describe how injury accurred	
Division of 'spiral or Attending Phours after death neral Director: After filled in by the funeral Certification: T	Accident Investigation  Accident Investigation Suicide 6 Could not be determined (Specify) Major Road / Highway  Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)  Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)  Route 32 @ Route 1, Savage, Md.	nber, City
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the Medical Certificati		
To with To con		
205	30. Name and address of person who completed cause of death (Item 23a)	
20	Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State Registrar	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2007 10:32 A M Arriaza June Lucrecio /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 01ney Montgomery Montgomery General Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Month, Days | Hours | Min. | November 9. Birthplace (State or Foreign Country) 2 Guatemala 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Funeral <sup>Year</sup>, 1942 1 M 2 □ F 64 Director 579-66-0503 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a, State 10b. County 1 ☐ Yes 2 No Director MD Silver Spring Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or Items 23a or the Medical Examiner must be 20905 USA 14700 Pebblestone Drive Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1X Yes 2 No Specify:Guatemalan Specify: white þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Self Employed Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12 Painter and Mental Hygie Is marked other permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maria Palencia Ascencion Arriaza ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 14700 Pebblestone Dr., Silver Spring, MD 20905 Fidelia Arriaza / wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Date 20c. Location - City or Town, State 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 0 June 6, 2007Alexandria, VA Crematory 22. Name and Address of Facility Francis J. Collins Funeral Home 21. Signature of Funeral Service Licensee 5 500 University Blvd. W, Silver Spring, MD 20901 000 Carres 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) INTERSTITIAL 1 10NET MONTH PULHOMARY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ner be executed burial-transit Exami and Due to (or as a consequence of) P.O. Box 68760, aftending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ARTERY DISCASE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No → 24a. Was an has autopsy performe certificate 1 Yes 2 No after death.

Director: After this certification by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ည 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital or within 24 hours a To the Funeral D completely filled 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ဂ္ D0058542 5 2007 wowlone 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) カス・レルリンミューサビーベレー Mン M CI CO VI C 、 1.9 G の S

State Registrar

31. Date filed (Month, Day, Year) 0 7

2007

32. Poistrar's Signature

DHMH 17 Rev 1/2001

CONCORD GTREET # 500, KENSIHGTON

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Frances Jane Adams June 2007 9:45 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chesapeake Woods Center Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🔀 F Director 218-20-6864 80 Dec. 23, 1926 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits iral", or Items 23a or 28a-f shov Examiner must be notified at Director Dorchester Cambridge 1 TYYes 2 □ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 525 Glenburn Avenue 21613 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify. Specify: white Completed by 3₺ Widowed 4 Divorced 'natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) crab picker seafood unknown other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be 1 Department of Health and Mental I is marked William Henry Bradford Grace T. Wingate ٩ Health and A 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry E. Adams daughter 3430 Chateau Dr., East New Market, MD 21631 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Important; If it any Injury or c 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Maryland Veterans Cem. 6/6/07 Hurlock, MD 21. Signature A Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. Kenn 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final failure disease or condition resulting in death) month Due to (or as a consequence of) 1 abetes Sequentially list conditions, if any, leading to immediate caus. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-trans Due to (or as a consequence of) Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9∏Unknown 9 Unknown signed by I be detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by dementiz 1 Yes 2 No 3 Probably 4 Unknown page 2 should Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed Drondru certificate 25. Was case referred to medic J examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Physician /Medical Examiner P.O. Box 68760.

filed within 72 hours after death with the

Baltimore, Maryland 21215-0036

requires that the death certificate be executed or Attending Physician: within 24 hours after death

To the Funeral Director: ,
completely filled in by the f Hospital

Division or Vital Records,

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

	Garrion	
) Name	and address of person who completed cause of death (Item 23a) (Type, Print)	

29d. Date signed (Month, Day, Year)

n 100 Brambil St, Cambridge, MD

32. Registar's Signature

State Registrar 29a. Certifier

(Check only one)

29b. Signature and title of certifier

07-04623 George Athev

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

eorge Amey		1- For State Certificate of Death Registrar	Reg	No. 20	07 2010		
Physicia	ın/	1. Decedent's Name (First, Middle,Last)	Date of Death     Month     I	Day Year	3. Time of Death 0857 hrs		
ledical Exami		George P. Athey  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	June 17, 20	07 4c. County of De			
		Western Maryland Health System - Braddock Campus  Cumberland		Allegany	saur		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	8. Date of Birth		Birthplace (State or		
Director		220-32-4107 1x M 2F 73 Yrs. Months Days Hours Min.	2/9/19:	34 Fo	reign Country) MD		
any	ł	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits		
*	٦	MD Allegany Cumberland			1 Yes 2 X No		
Maryland 28a-f show d at once.	Director	10e. Street and Number 10f. Zip Code	10g	. Citizen of What (	Country?		
h the Maryland 3a or 28a-f sho		16802 Collier Run Road 21502		USA			
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.  unt: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 X Married   12. Was Decedent Ever in U.S.   Armed Forces?   1 X Yes 2 No   13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race - Ar White, et	merican Indian, Black, c.		
after	by F	3 Wildowed 4 Divorced If Yes, Give Year Korean 1 Yes 2 X No specify:		Specify: W			
hours matur Exam		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retired to the property of the pro		6b. Kind of Busine	ess/Industry		
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21215-0036 uld be filed within 7. Mental Hygiene. marked other than c event, the Medical	Be		Silber				
nore, MD 21215-00: ages I and 2 should be filed with nt of Health and Mental Hygiene It: If item 27 is marked other t other traumatic event, the Mer	٩	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or F					
MD and 2 sho ealth and em 27 is raumati		Helga Athey/wife 16802 Collier Run Ro.  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery.		20c. Location - Cit			
Ore		1 X Burial 2 Cremation 3 Removal from State crematory or other place)	ł				
8 2 0			21/2007		land, MD		
Balt permit. Departs Import		21. Signature of Friefal Genyice Licens  22. Name and Address of Facility Sca 108 Virginia Ave.,	rpelli F Cumberl	uneral Ho and, MD 1	21502		
Physician		26s. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	r respiratory arres	t, shock, or heart	Approximate Interval Between Onset and		
/Medical Examiner		Immediate Cause (Final disease a. Multiorgan Failure			Death		
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	Examiner	cause. Enter Underlying Cause					
IN E &	Exa	events resulting in death) Last  Due to (or as a consequence of):					
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60, ate be hysici	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of del	ivery		
687 ertific ding p		23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregna	incy	Month	Day Year		
eath c atten for us	Physician/	4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown g Unknown					
D. E		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribut	e to the cause of death?		
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ords, w requir	lete		24a. Was ar autops		e autopsy findings available to completion of cause of		
eco he law ite has	Completed		perform	ned? deat			
Vital Rec ysician: The his certificate director, page	Be C	25. Was case referred to medical 26.Place of Death (Check	only one)				
Vita hysici this ca	9 9	examiner? 1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other Nursin	ng Home 5 R	tesidence 6 0	Other:		
n of VI ling Physi After this funeral dir	ü	27. Manner of Death 28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?	28d. Describe ho	ow injury occurred			
Sior Mitend death death oy the	catic	2 Accident Investigation	006 1	root and Number o	a Dural Davida Number City		
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lospit: 4 hour uners		29a. Certifier   Continue   Developer   To the heat of my knowledge death occurred at the time date and place and	due to the cause	(s) and manner as	stated.		
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	at the time, date a	nd place, and due	to the cause(s)		
F × S	Me	29b. Signature and title of certifier 29c. License number		_	(Month, Day, Year)		
		Cheol Halla O.C.M.E.		June 18, 200	7		
		30. Name and address of person who completed cause of death (Item 23a)	.4				
		Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120					
St Regis	ate trar	31. Date filed (Month) Dev. Year 2007 32 Registrar's Signature					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2007 11:27 AM **Physician** BURRISS PEARL JUNE 4 T.TT.T.TAN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY OLNEY MONTGOMERY GENERAL HOSPITAL 8. Date of Birth (Month, Day, Nov. 16 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6 Sex Social Security Number 5 1922 Days Hours **Funeral** Months Tennessee 1 ☐ M 2 💢 F 84 216-20-1576 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No Olney Montgomery Director Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20832 #101 17821 Buehler Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No White Baltimore, Maryland 21215-0036 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping House Cleaning 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Kampa Lee Rhea Sherman P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Buehler Road, #101, Olney, Md. 20832 17821 Phyllis K. Grimes/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If it
any Injury or o 1 ☐ Burial 2 🗹 Cremation 3 ☐Removal from State Alexandria, Va. 6/7/07 Metropolitan Crem. 4 ☐ Donation 5 Other (Specify) 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Service Lice Box 5038, Laytonsville, Md. 20882 00470 P. 0. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 131.00 Physician Ardiac /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical attending p IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐ Ectopic p Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (spec been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 10 cate has I 1 ☐ Yes 2 - No 1 Yes certificate Division or Vital or Attending Physician: 26. Place of Death (Check only one 25. Was case referred to medical funeral director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ☐ ER/Outpatient 3 DOA 1 Yes 2□ No 1 🔲 Inpatient 10 After this 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: (Month, Day Year) Injury 5 Pending investigation 1 A Natural 1 ☐ Yes 2 ☐ No 2 Accident death To the Hospital or Attend within 24 hours after death To the Funeral Director; the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State

31. Date filed (Month, Day, Year) JUN 0 Registrar



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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		•	For State Registrar	State of Maryland		artment of F		nd Mental H	ygien Reg. N	0007	20105	
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Fur	neral		5. Social Security Number 6. S		ast birthday)	If Under 1 Year	If Under 24		Birth		nplace (State or Foreign untry)	
	ector		727-05-6747	(XM 2□ F	85 Yrs.	Months Days	Hours	Min. (Month, I July 3	Day, Year $1$ , $1$		ryland	
and			Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits	
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and 2 sh	er tra		Margaret Smith	/ Daughter			rive,	Derwood,	-			
<b>Saltimore,</b> Demit. Pages 1ar Department of Hea	io to		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐	Removal from State	emetery, crer	sition (Name of natory or other plac		Date		Location - City or		
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To the within 2	сошь	Me	29b. Signature and title of certifier	1//	1	29c. Licens			29d. D	ate signed (Monti	h, Day, Year)	
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12+	'		30. Name and addres person who	completed cause of death (Item	1 23a) (Type,	Print)		ATIONAL N			CENTER	
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r	Physici /Medic	_	Robin			Barnh	art		Month	Da		ar	7308 PM
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	th the or 28; e not	Director	10e. Street and Number			_	f. Zip Code			10g. Cit	izen of Wha	t Coun	try?
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	e file al Hy dothe	Be (	17. Father's Name (First, Middle, Last	)				18. Mother's Nam	ne (First, Middle	e, Maider	Surname)		
yla	Duld by Ment arked	일	Conway Clyde Ga					Mildred	Lu Bra	ander	burg		
Maryland	2 should be f and Mental H Is marked ot raumatic ever		19a. Informant's Name/Relationship (			. Mailing Add	dress (Street	and Number or Ru	ral Route Numi	ber, City o	or Town, Sta	te, Zip	Code)
	1 and Health		Rick W. Barnhar  20a. Method of Disposition	t - Husbar				lvania Av	enue, I		stown		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2X Cremation 3 ☐		20b. Place of cemete						·		
三	it. Partmel		4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lices	•	Hage		n Crema	atory 6/1	1/0/ [innich			-	Maryland
Ba	Depai Impor any Ir		1800 TO Q 6	Porli				lson Blvd					1740
			23a. Part1. Enter the disease, or com	plications that caused	I the death. Do								Approximate Interval Between
	Physician		Immediate Cause (Final										Onset and Death
	/Medical		resulting in death)	a.  Due o (or as	a consequence	of):							s days
5	Examiner	,	Sequentially list conditions.	b. Cirrho								1	year
	sit ad	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	of):									
_	and F-tran	Examiner	that initiated events teasing in death) Last Due to (or as a consequence of):									1	year
68760,	tificate be executed ig physician and as the burial-transit	alE		(	<b>-</b>								
9	ificate g phys	edical		d									-
ŏ	n cert anding use a	n/m	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		ه ⊏ح					23d. Date of	f delive	ry
Division or Vital Records, P.O. Box	The law requires that the death cer ate has been signed by the attendir bage 2 should be detached for use	Completed by Physician/M	in the past 12 months? 1 □ Yes 2 🗷 No	4□Pregnant a	2 Fetal death time of death	3 □Ectopic pregnancy 5 □ Other (specify)					Month Day Year		
o.	at the by th tache	hys	9 ☐ Unknown	9□Unknown									
Š,	es tha	by F	Part II. Other significant conditions		23e. Did tobacco use contribute to the cause of								
ord	requii	ted		Disease						Yes 2	No 3	Prob	ably 4 □Unknown
ec	2 SE C1	nple	Alcoholism						24a. Was	opsv	prior	r to con	osy findings available npletion of cause of
a E	i: The		uterine Carcino	ma					pen 1⊟ Yes	formed? 2 X No	death? 1 ☐ Yes 2 ☐ No		
Ĕ	sician: The law certificate has b irector, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:			J DOA Oth	26. Place of Dea					-
ō	Phys r this ral di	<u>유</u>	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ≥ Inpatie	ent 2 ER/Ou	itpatient 3[ Time of	7 DOY	4 LI Nursing H	ome 5 ☐ Res 28d. Describe			Specify	)
on	Attending Physician: r death. ector: After this certifics by the funeral director, p	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	<i>(Month, Da</i> n	y Year) I	njury M	28c. Injur Wor	ḱ? Yes 2∐No		ibe now injury occurred			
<u>S</u>	Atter	ifica	3 ☐ Suicide 4 ☐ Homicide  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)							(Street a)	nd Number o	r Rura.	l Route Number,
	tal or s afte al Dir ed in	Certification:	4 Littornede	building, et	c. (Specify)				City of Te	City or Town, State)			
	Hospi 4 hour Funer tely fill		(Check only 2 Medical Exal	nysician: To the best miner: On the basis o	f examination ar	e, death occu nd/or investig	rred at the tir ation, in my o	me, date and place opinion, death occu	e, and due to the irred at the time	e cause(s e, date an	and manne d place, and	er as st	ated. the cause(s)
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	one)  29b. Signature and title of certifier	and manner st	ated.		29c. Licens	e number		29d. Da	ate signed (N	fonth.	Day, Year)
1	F > F 8	-	1 July Fitt	IM MD				-000		رن			007
,			30. Name and address of person who	1111	eath (Item 23a)	(Type, Print)						,	
	-208. 8		TORIN FIT TON					, BALTI	MORE.	MAR	4LAND		
	Sta		31 Date filed (Month, Day, Year)	32. Registr	ar's Signature	1	w .	, BALTI					
	Registr	ar	JUN 12	2001	m D.	Agen							

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar		(	Certificate of	f Death	F	Reg. No. 2 0 0 7	20107		
€.	Physicia	an	1. Decedent's Name (First, Middle, Last)					Date of Dea     Month	ath Day Year	3. Time of Death		
	/Medic		MARTHA IRENE BRO					JUNE	9, 2007	113 M		
1	Examin	er	4a. Facility Name (If not institution, give s	treet and number)			or Location of Deat	th	4c. County of Dea			
	Francis		49 S. MAIN STREET  5. Social Security Number 6. Sex	7. Age	(In yrs. last birtho		OONSBORO ur   If Under 24 Hrs	8. Date of Birth		HINGTON thplace (State or Foreign		
į,	Funeral Director	1  M 2  XF							v, Year) C	MARYLAND		
	yland now at		10a. State 10b. County		10c. City, Town o	or Location				10d. Inside City Limits		
	a-f st	ctor	MARYLAND WASHI	NGTON		ВО	ONSBORO			1X Yes 2 No		
	ith the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?		
	ath w s 23a nust t		49 S. MAIN STREET				21713			S.A.		
	ter de items	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ev Armed Forces? 1 □ Yes 2 X No	ver in U.S.	13. Was Decedent of If Yes, specify Co	f Hispanic Origin? (S Jban, Mexican, Puer	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Whi			
336	urs aff	by F	3 MWidowed 4 □ Divorced	If Yes, Give Year or Dates:	·	1 □ Yes 2 <b>X</b> N	o Specify:		Specify:	WHITE		
200	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or items 23a or 28a-f show snt, the Medical Examiner must be notified at	ted	15. Decedent's Educ (Specify only highest grade		16a. D	ecedent's Usual Occ Give kind of work don	upation	rking	16b. Kind of Business			
21	ithin 7 ne. nan "i	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	<del></del>	ife. DO NOT use reti	red)	, King				
72	Hygier Hygier Ther th	S	17. Father's Name (First, Middle, Last)			HOMEM	T	me (First Middle	OWN Maiden Surname)	HOME		
anc	d be f ental h ced of	) Be		DIETI CD					,			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	으	VFRNON WILLIAM SHI 19a. Informant's Name/Relationship (Type	,	19b. N	failing Address (Stre		LIZABETH Jural Route Numbe	DAYH()F'F' er, City or Town, State,	Zip Code)		
	and 2 alth a 27 is		VERNON BROWN, SON		49	S. MAIN	STREET, B	OONSBORO	, MARYLAND	21713		
ore	es 1 a of He of He fitem		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	amount from State	20b. Place of D	isposition (Name of crematory or other p		Date	20c. Location - City or	Town, State		
<u>Ĕ</u>	Pag ment tant: I		4 Donation 5 ☐ Other (Specify)		BOONSBO	ORO CEMETE		3/2007	BOONSBORO	, MARYLAND		
Baltimore,	permit. Depart Import any Inj once.		21. Signature of Funer Service License	re 7		22. Name and Add	-		D NATIONAL	PIKE		
	ED = 60	111	23a. Part1. Errer the disease, or complic	odtions that caused t	he death. Do not				RO, MARYLAN	VD 21713 Approximate		
			shock, of heart failure. List only on Immediate Cause (Final	e cause on each line		•		ic of respiratory at	1651,	Interval Between Onset and Death		
	Physician /Medical		disease or condition resulting in death)	. Due to (or as a	nsequence of)	Cancer				2 months		
n	Examiner											
	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		ue to (or as a consequence of):							
	ecute and trans	Examine	that initiated events c. resulting in death) Last		e to (or as a consequence of):							
60,	be exiclan	al E	but to (or us a ventequence of).									
68760,	rtificate be executed ng physician and sas the burial-transit	Medical	d		-							
Вох	S E		IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome p		۰۵۵			23d. Date of de	elivery		
œ.	death	sicia	in the past 12 months? 1 ☐ Yes 2 <b>X</b> No	1 ☐Live birth 2 4 ☐Pregnant at ti 9 ☐ Unknown		3 ☐ Ectopic pregnar 5 ☐ Other (specify)			Month	Day Year		
P.O.	at the i by th stache	Physician/	9 Unknowh									
ŝ	The law requires that the death ate has been signed by the atter bage 2 should be detached for u	by	Part II. Other significant conditions con Gastroin Portal	tributing to death but	not resulting in the	ne underlying cause g	given in Part I.	23e. Did to	obacco use contribute t ⁄es 2□No 3□P	o the cause of death?		
Š	requipeen should	Completed	9-1-1	Halblala.	ción			WAY				
Rec	ne law has l ge 2 s	mp	Yoym	Hyperpa	73(47)			24a. Was autop				
<u>a</u>	ilclan: The lav certificate has ector, page 2		25. Was case referred to medical				Of Diago of Do	1□ Yes	2No 1 ☐ Ye	s 2 No		
>	Attending Physician: or death. ector: After this certificity the funeral director,	To Be	examiner?	lospital:	t 2 ER/Outpa	atient 3 DOA	thor.	- 4	dence 6 ☐Other (Spe	acify)		
0	ding Phys n. After this funeral dii		27. Manner of Death	28a. Date of Injury (Month, Day	y 28b. Tin	ne of 28c. In			now injury occurred	,,,,,		
Sior	endlin sath. or: Af he fur	atio	1 Natural 5 Pending investigation	(Morali, Day	7001)		☐Yes 2☐No					
Division or Vital Records,	or Attendater death	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury building, etc.		, street, factory, offic	е	28f. Location (S City or Tow	Street and Number or Fi vn, State)	lural Route Number,		
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h. completely filled in by the funeral director, page		29a, Certifier 1X Certifying Phys	sician: To the best of	my knowledge	leath occurred at the	time data and alac	e and due to the	cause(s) and manner a	e etatori		
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	(Check only 2 Medical Examin	ner: On the basis of e	examination and/	or investigation, in m	y opinion, death occ	curred at the time,	date and place, and du	e to the cause(s)		
	To the within To the complete	Me	29b. Signature and title of certifier	***		29c. Lice	nse number		29d. Date signed (Mon	th, Day, Year)		
)			1 Zam	12	-	D	44996		June 11,	2007.		
			30. Name and oddresnot person who con	meleted cause of dea	ath (Item 23a) (Ty	(pe, Print)	nanc Da	1 Renn	dow Mh	2/7/7		
	1-2		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	41 04/1	veri> KA	()001)		-113		
	Sta	te	IIIN 1 0 00		Joignature	/						

			se Type or Pri			delible Inka		-		egible.		
		1 - State Registrar			Ce	rtificate of	Death		Reg. No.	007	20103	
		Decedent's Name (First, Middle	e, Last)					2. Date of De	eath Day	Year	3. Time of Death	
Phys /Me	ician dical	Robert Kagel :	Baird, Sr.					June	5	2007	1:30 AM	
	niner	4a. Facility Name (If not institution					or Location of Dea			ounty of Death		
		Somerford Pla					Annapoli:			ne Aru		
Funer		5. Social Security Number 398–07–3261	6. Sex 7. A	ge (In yrs. last b <b>84</b>	<i>irthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	1. (Month, Da	ay, Year)		place (State or Foreign ntry)	
Directo	or	Usual Residence of Decedent		04				Jan.	4, 192	23 W.	isconsin	
/land low		10a. State 10b. County		10c. City, Tox	wn or Lo						10d. Inside City Limits	
Mar a-f sh ified	tot	Maryland Anne	Arundel			Ann	napolis				1 ☐ Yes 2 XNo	
th the or 28s	jre	10e. Street and Number				10f. Zip Code			10g. Citize	n of What Cou	ntry?	
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral Director	1724 Woodlore	Road				21401			U.S.A		
r dea terns	Tue	11. Marital Status	12. Was Decedent Armed Forces	?	13.	Was Decedent of F If Yes, specify Cub	-lispanic Origin? ( an, Mexican, Pue	Specify Yes or No orto Rican, etc.)	0- 14	. Race - Americ Black, White,		
36 s afte ; or i	by F	1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 ☐ Yes 2€5 If Yes, Give Year or Dates:	<b>(</b> No		1 ☐ Yes 2 🗷 No	Specify:		s	pecify: Wi	nite	
bour lour al Ex	d be	15. Deceden		16	a. Dece	dent's Usual Occup	pation		16b. Kind	of Business/In	ndustry	
115 in 72 n "na Medic	plet	(Specify only higher	st grade completed)		(Give	kind of work done DO NOT use retire	during most of we	orking	Ī		,	
21215-0036 d within 72 hours af giene. er than "naturai", or the Medical Exami	Completed	Elementary/Secondary (0-12)	College (1-4or	3+)		Sales			Phar	maceut:	icals	
othe vent,	S S	17. Father's Name (First, Middle,	,					ame (First, Middle	e, Maiden S	urname)		
arylance should be figure Mental Head of Semarked of S	To Be	Matthew J. Ba:	ird				Hild	da Kagel				
Maryland  of 2 should be file lith and Mental Hy 27 Is marked oth r traumatic event	Ι.	19a. Informant's Name/Relations		19	9b. Maili	ng Address (Street	and Number or F	Rural Route Numb	ber, City or	Fown, State, Zij	p Code)	
and and m 27	1855	Betty Baird/w	ife	Look Bi		4 Woodlor		Annapol:			21401	
Baltimore, bermit. Pages 1 a Department of Hei Important: If Item any injury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 ☐Removal from State	20b. Place cemet	of Dispo	osition (Name of matory or other pla		Date		tion - City or T		
timentant:		4 □ Donation 5 □ Other (S		Rice		metery	6/1	15/2007	Elkh	art, I	ndiana	
Baltimore, Maryland 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Marylan pepartment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	ouce	21. Signature of Funeral/Service	Licensee A			2. Name and Addre						
EXPENSE:		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause	ed the death. Do						apolis	MD 21401 Approximate Interval Between	
Dhu-iai-		shock, or heart failure. List Immediate Cause (Final	only one cause on each I	1111	-			,	,		Interval Between Onset and Death	
Physicia /Medica	_	disease or condition resulting in death)	a. Due to (or as	1 Zhei		s Wist	ase					
Examine	er			-	,-							
	je l	Sequentially list conditions, if any, leading to immediate cause. Entire fundanting that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):										
cuted nd ransit	amij											
60, be executed ician and bunal-transit		resulting in death) Last Due to (or as a consequence of):										
0 0 00	Physician/Medica		d									
x 6 ertific	Mec	IF FEMALE:	23c. If yes, outcome	o of prognancy								
Bo sath c attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth	2 Fetal dea		☐Ectopic pregnanc	СУ	23	23d. Date of delivery  Month Day Year			
I Records, P.O. Box 687  The law requires that the death certificate the has been signed by the attending physoage 2 should be detached for use as the	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐Unknown	at time of death	31	Other (specify)			_ 1			
that the by detail		Part II. Other significant condition	ons contributing to death	but not resulting	in the u	ınderlying cause gi	ven in Part I.	23e. Did	tobacco us	e contribute to	the cause of death?	
Records, The law requires to has been signed age 2 should be contacted.	d by							1 🗆	Yes 2	100 3 ☐ Pro	bably 4 □Unknown	
cord w requir	lete							24a. Was		24b. Were aut	opsy findings available	
Re Is te has age 2	Completed								opsy formed? 2	prior to co death? 1 ☐ Yes	ompletion of cause of 2 No	
	BeC	25. Was case referred to medica	l				26. Place of D	eath (Check only				
or Vita Physician: rthis certifica	10 E	examiner? 1 D Yes	Hospital: 1 ☐ Inpat	ient 2 ☐ ER/C	Outpatie	nt 3□ DOA Otl	her.	Home 5□Res			_	
ng Pl		27. Manner of Death  ↑ Tatural 5 □ Pendin	28a. Date of Inj (Month, D	ury 28b ay Year)	Time o	of 28c. Inju	iry at ork?	28d. Describe	how injury	occurred		
Vision Attending r death. ector: After	cati	2 ☐ Accident investig	gation				]Yes 2 □ No	00/1	(0)			
Division if or Attending after death. I Director: Afte	Certification:	4 Homicide determ	singel   Zee, Place of II	etc. (Specify)	rarm, st	reet, factory, office		City or To	own, State)	Number or Hul	al Route Number,	
e Hospital 24 hours a e Funeral I		29a. Certifier Certifyi	g Physician: To the bes	t of my knowled	lae. dea	th occurred at the t	ime, date and pla	ice, and due to the	e cause(s) a	ind manner as	stated.	
e Hos 24 hc e Fun etely	Medical		Examiner: On the basis and manner s	of examination a								
Division o  To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Me	29b Signature and title of certifie				29c. Licens	se number			signed (Month		
		1 CM				7	58166		Ju	ne 5.	2007	
		30. Name and address of person	who completed cause of	death (Item 23a	a) (Type		- U			/		
IACH	+	Dr. Eric Mar	calus 3169	Bravert	on I	Road #10	1 Edgev	water, Ma	arylar	d 2103	37	
	State	31. Date filed (Month, Day, Year)	6 2007 32. Pgis	trar's Signature	,	land.						
Heg	istrar	3011 0	0 2001	m s	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 9:10 AM 2007 Michael Ciske Bond June 6, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Southern Maryland Hospital Center Prince Georges Clinton Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) Days **Funeral** Months Hours 1 X M 2 □ F Maryland Director 48 06/25/1958 220-66-8943 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10h. County "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐Yes 2X No Director Maryland | St. Mary's Loveville 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20656 United States 28475 Point Lookout Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. illed within 72 hours after 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Black <u>م</u> 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Construction Construction Worker 12 Department of Health and Mental Hyg. Important: If item 27 is marked other any Injury or other them. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Shirley Elizabeth Woodland King Philip Bond, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Box 2438, Leonardtown, Maryland 20650 Sharron Bond/ Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 06/15/2007 | Helen, Maryland Queen of Peace Cem. 4 Donation 5 Other (Specify) 21. Signature Funeral Gryice Lice see 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. and Death
MOVIU OTOP ATTHO Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed physician and strans Due to (or as a consequence of): Box 68760. Physician/Medical attending p as IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) o 9□Unknown 9 Unknown ģ ۵. signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 certificate has autopsy performe rmeg? 2**V2 N**o 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 1 ☐ Yes this funeral Date of Injury (Month, Day Year) 27. Manner of Death 28a 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification; Hospital or Attending Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. hours after death uneral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide hin 24 hours at the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatu/s/and title of certifier 2

State Registrar 32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

address of person

31. Date filed (Month, Day, Year)

JUN 1 3 2007

RCVE

			1 _ State	State of Maryland		artment rtificate			and M	, ,		2007	201	
8		æ.	Registrar  1. Decedent's Name (First, Middle, Last)			imoure	. 0, 2	Journ	Т	2. Date of Dea	Reg. No.	2001	3. Time of E	Death
	Physic		Dale Whittir	gton Bro	wn	Sr.			.+	Month Tung	Day	/ Year <b>2007</b>	1924	М
Y	/Medi Examir		4a. Facility Name (If not institution, give sa		WII		own, or	Location o		14106		County of Death		
			Peninsura Regional	Medical Co	11/4		50	9/13/14	14			Hicim	00	
	Funeral		Social Security Number     6. Sex	7. Age (In yrs. Ia M 2		If Under 1 Months	Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	h /, Year)	9. Birth	place (State or intry)	Foreign
	Director		218-24-2735	M 2LIF 77	Yrs.	monario	Dayo	Tiodio		6/2/1			nnsylva	nia
	and		Usual Residence of Decedent  10a, State 10b, County	10c. City,	Town or Lo	cation				12, 12, 13			10d. Inside City	
	Marylan f show ed at	ō	Manual and this are										1 ☑ Yes	
	the t	Director	Maryland Wicomico  10e. Street and Number	) Sal	isbur	10f. Zip (	Code				10a. Citi:	izen of What Cou	intry?	
	be filed within 72 hours after death with the Maryland ntal Hyglene.  sid other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at		318 Brookdale Dri	ve			2180	4			3	USA		
	death ms 2	Funeral	11. Marital Status 1	2. Was Decedent Ever in U.S Armed Forces?	. 13.	Was Decede	ent of His	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		14. Race - Ameri		
9	after or ite mine		1 ☐ Never Married 2 ☐ Married	1 XYes 2 No	.	ıı res, speci 1 ∐ Yes 2		Specify:	i, Puerto	Hican, etc.)		Black, White	, etc.	
93	ours iral";	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates: Coas	9	10 165 2	-XIVO	оресну.				Specify:	white	
21215-0036	72 h "natu	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece (Give	dent's Usual kind of work DO NOT use	Occupa done d	ation Juring most	t of worki	ng I	16b. Kii	ind of Business/li	ndustry	
121	within lene. than he Me	ם	Elementary/Secondary (0-12)	College (1-4or 5+)			retirea)	ı			<b>~</b> 1			
d 2	filed v Hygie Ither i		12 17. Father's Name (First, Middle, Last)		Cap	tain_		18. Mothe	r's Name	(First, Middle,		narter E	oat	
an	d be	o Be	Harry M. Brown						h Bi		141414011	ourname,		
Maryland	2 should be filed and Mental Hygis Is marked other aumatic event, II	ပ္	19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mailir	ng Address	Street a				er. Citv o	or Town, State, Zi	in Code)	
			Marilouise Brown/w	rife						lisbury	-		,,	
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If Item 27 i any injury or other tra once.		20a. Method of Disposition	20h. Pla	ce of Dispr	sition (Nam	e of			ate		ocation - City or T	own, State	
Ę	Pages nent of int: If It		1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State Wic		matory or other Memor	ial	=) :	6/9/	07	Sal	lisbury,	MD	
alti	permit. Departm Importal any inju		21. Signature of Funeral pervice Ligense			2. Name and	Addres	s of Facilit	v					
m	Departing Important any irronce.		> ///KIdWe	M. CFSP		501 S	way now	Funei	ral 1 Rd.	dome Pro , Salis	oies burv	sional A	Associa: 804	tion
	Physician /Medical Examiner		23a. P Enter the disease, or common shock, or heart failure. List only on immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence	lic	ter the mo		g, such as		or respiratory ar	rest,		Approximate Interval Betw Onset and D	/een
8760,	cate be executed obysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque										
O. Box 6	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as!	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome pf pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	⊒Ectopic pre ⊒ Other <i>(spe</i>					2	23d. Date of deli		ear
rds, P.	quires that in signed b	þ	Part II. Other significant conditions con	ributing to death but not resul	ting in the u	nderlying ca	use give	n in Part I.		23e. Did to		use contribute to ☐ No 3 ☐ Pro		eath? nknown
Records,	The law requir ate has been s bage 2 should	Completed								24a. Was a autop perfor	sy	prior to c death?	topsy findings a ompletion of cal 2 No	vailable use of
Vital	ysician: The is certificate hadirector, page	Be C	25. Was case referred to medical examiner?					26. Place	of Death	(Check only o	-X	1 12100		
or V	Physician: this certific ral director,	은	1 ☐ Yes 2 No	ospital: 1 Inpatient 2 ☐ E	R/Outpatier	nt 3□ DO/	Othe	er: 4 🗆 Nu	rsing Ho	me 5 Resid	dence (	6 □Other (Spec	ify)	
ion o	ding I. After fune		27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28	lc. Injury Work	rat ? /es 2∐I		28d. Describe h	now injur	ry occurred		
Division	To the Hospital or Attend within 24 hours after death.  To the Funeral Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At hon building, etc. (Specify)	ne, farm, str	eet, factory,	office		1	28f. Location (S City or Tow	Street an vn, State	nd Number or Ru e)	ral Route Numb	er,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	edical	29a. Certifier (Check only one) (Check only one) (Check only one)	cian: To the best of my know er: On the basis of examinati and manner stated.	ledge, deat on and/or in	h occurred a vestigation,	it the tim	ne, date an pinion, dea	nd place, oth occurr	and due to the ed at the time,	cause(s) date and	) and manner as d place, and due	stated. to the cause(s)	
	V V Within	M	29b. Signature and title of certifier	unt Il	u	29c.	7) 3	number 3 074	13		29d. Dat	te signed (Month	, Day, Year)	
	09/18		30. Name and address of person who con Benjamin H. Meyer	npleted cause of death (Item	17	Print) Share	- 1)1	e, 5	alisi	buey	MA	2180	4	
	St	ate	31. Date flied (Month, Day, Year)	32. Registrar's Signati						1				

JAK W. DOOWN

Registrar JUN 0 8 2007 400 Eastern
32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 12 Day 2007 ar **Physician** 11:57P M Burroughs Catherine Ε. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Southern Maryland Hospital Clinton 6. Sex 7. Age (In yrs. last birthday) if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 87 Yrs. 213-44-3422 10,1920 Md. Director March Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ——any injury or other traumatic events. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 1 Yes 2 □ No Director PG Md. Temple Hills 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6101 Harley Lane 20748 United States Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify 3 Nidowed 4 Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Nursing Assistant Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George ို Greer Rachel Ross 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6101 Harley Lane Temple Hills, Md Sharron Tesemma/daughter 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Tremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Crematory 6/18/07 Riverdale, Md. 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licensee 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a rdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as Physician/Medical Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 morths? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by to Part II. Other significant conditions contributing to death but got resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 dunknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♣ No 24a. Was an certificate has birector, page 2 s autopsy 2 No 1☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending investigation Injury n 24 hours after death.

le Funeral Director: At 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and aggress of person who completed cause of death (Item 23a) (Type, Print) 10 Obafemi Opesanmi 7503 strar's Signature Ma D 32 Regis Surratts Rd., Clinton, Nay, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician 950 a Camp 05 oster 2007 awrence /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett County Hospital Oakland Garrett | If Under 1 Year | If Under 24 Hrs. | B. Date of Birth (Months | Days | Hours | Min. | 08/23/ Birthplace (State or Foreign Country)
 WV 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1XM 2□ F 83 Yrs. 1923 235-22**-**4254 Director Usual Residence of Decedent deeth with the Meryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location It is marked other than "neturel", or Items 23e or 28e-f show treumetic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Preston Horse Shoe Run 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code Rural Route 1 Box 254-1 26716 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) is 1 and 2 should be filled within 72 hours after of Health and Manlel Hyglene.
Item 27 te marked other then "neturel", or Item treumelt event, the Medical Examinate other treumette event, the Medical Examinate. 1 Never Married 2 Married 1 Yes 2 No Baitimore, Maryland 21215-0036 Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Farmer Agriculture 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Gus Lawrence Calcamp Lura Agnes Harsh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rt. 1 Box 254-1 Eglon, WV26716 Lucy W. Calcamp/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Peges 1
Department of HImportent: if Iter
eny Injury or oth Burial 2 Cremation 3 Removal from State Eglon, 4 ☐ Donation 5 ☐ Other (Specify) Accident Cemetery 05/25/07 21. Signature of Filmeral Service Hinkle Funeral Home, Inc. P.O. Box 186 Davis, WV 26260 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deal Immediate Cause (Final hamon [a Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Examine The law requires that the death certificate ba executed ettending physicien and for use as the buriel-trensit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ě 1 Yes 2 No 3 Probably 4 Monknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 24a. Was an autopsy 2 2 10 1 Yes or Attending Physicien: 25. Was case referred to medical 28. Place of Death (Check only one) Be Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: To the Hospitel or Attending within 24 hours efter death. To the Funerel Director: Atte completely filled in by the fune ty Natural 5 Pending м 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mariner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature anaptitle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5,22, 7 Da3979 ss of person who completed cause of death (Item 23a) (Type, Print) 311 North 3rd i MD Robert Gorals 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 1 2007

DHMH 17 Rev 1/2001

Registrar

			1- State of Maryland / Department of Health and Certificate of Death	Men		gie Reg.	C 0 0 1	201	13
E	Physici	ian	1. Decedent's Name (First, Middle, Last)		Date of De		Day 2007 Year	3. Time o	
	/Medi	cal	Margaret W. Conelley  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Deal		ne .	5 <b>,</b>			рм
	Examir Funeral Director	ner	Hebrew Home of Greater Washington  5. Social Security Number  6. Sex 1 □ M 2√□ F  7. Age (In yrs. last birthday)  Yrs.  1 □ M 2√□ F  1	s. 8. D	Date of Bir Month, Da	ау, Үө	ear) Cou		or Foreign
	land		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	- 01			340	10d. Inside C	ity Limits
	Mary -f sho	tor	Maryland Montgomery Kensington						2 🗌 No
	death with the Maryland ms 23a or 28e-f show r must be notified at	al Directo	10e. Street and Number 3419 Plyers Mill Road 20895			10g.	Citizen of What Cou USA	intry?	
5-0036	be filed within 72 hours after death with the Marylan tal Hygiene. d other then "neturel", or items 23a or 28e-f show event, the Medical Examinat must be notified at	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, specify Cuban, Mexican, Puer If Yes, Give Year or Dates:	Specify \ rto Ricar	Yes or No n, etc.)	)-	14. Race - Ameri Black, White Specify: Whi	, etc.	
N-612	filed within 72 ho Hygiene ther then "netur ent, I'm Medicel	Completed	15. Decedent's Education (Specify onfy highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of wo	orking		16b	. Kind of Business/Ir	ndustry	
7	filed w Hygien sther th		4 Graphic Artist  17. Father's Name (First, Middle, Last)  18. Mother's Na	mo /Fim	at Middle	Mais	Museum		
and		To Be	17. Father's Name (First, Middle, Last)  David D. Wright  18. Mother's Na  Virgin			, IVIau	den Surname)		
Mary	2 should be and Mental Is marked (eumatic ev	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or R	Rural Rou	ute Numb	er, Ci	ty or Town, State, Zi	p Code)	
ข์	1 and Health sm 27 ther tr			Kei Date ine	nsin		on, MD 208 Location - City or T		
Baitimor	permit. Pages Department of I Important: If it any injury or o		*4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility Francis J. Colling 500 University BI	200° ns Fi Lvd.		Al al Sil	exandria, Home Inc. ver Sprin	Virgi a. MD	nia
			23a. Part1. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.					Approximatinterval Bet	te
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. METASTATIC LETOMYOSAGE					Onset and	
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09/90	eath certificate be executed attending physician and for use as the burial-transit	edical	d						
O. Box	0 0	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐				23d. Date of delive Month	-	Year
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al necc	The lay ate has page 2	Completed			24a. Was autop perfo		? death?	impletion of c	available ause of
VII	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1   Yes   2   No   Hospital: 1   Innatient   2   EB/Outpatient   3   Doa   Other: 4   EB/Outpatient   3   Doa   Oth						
0 0	ding Phys th. After this funeral di	-	1   Yes 2   No   Note of Land   1   Inpatient 2   ER/Outpatient 3   DOA   One of Land   4   Note of Land   28a. Date of Injury   28b. Time of Land   28c. Injury at Work?   2   Accident Investigation   M   M   1   Yes 2   No				6 □Other (Special njury occurred	fy)	
DIVISION	To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification;	3   Suicide 4   Homicide  6   Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. L	ocation (Sity or Tox	Street vn, St	and Number or Run ate)	al Route Num	ber,
	ne Hospit 24 hours ne Funere	edical (	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time 2 Medical Examiner: On the basis of examination and on the time 2 Medical Examiner: On the basis of examination and on the time 2 Medical Examiner: On the basis of examination and on the time 2 Medical Examiner: On the basis of examination and on the time 2 Medical Examiner: On the basis of examination and on the time 2 Medical Examiner: On the basis of examination and on the time 2 Medical Examiner: On the basis of examination and on the time 2 Medical Examiner: On the basis of examination and on the time 2 Medical Examiner: On the basis of examination and on the time 2 Medical Examiner: On the basis of examination and	e, and di urred at	ue to the the time,	cause date a	e(s) and manner as s and place, and due t	tated. o the cause(s	i)
		M	29b. Signature and title of certifier  29c. License number  0024942	2			Date signed (Month,	4	67
	12		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  GNEGSTY A. COMPTON 6/21 MONTROSE R	D (	Ruc				
To Re	Sta Registr		31. Date filed (Most Day, Year) 2007 32 Registrar's Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 2007 Michael Richard Campbell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number Sex X□M 2□F 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 0 Maryland 1 June 8,2007 Director Usual Residence of Decedent r 28a-f show notified at 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County Franklin Pennsylvania 1 ☐ Yes X☐ No Director Waynesboro 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or 5 with 1 "natural", or Items 23a 815 Mountain View Rd 17268 U.S.A. hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A n s 1 and 2 should be filed w of Health and Mental Hygier item 27 is marked other the other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Natalie A. Campbell Andrew K. Campbell ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Natalie Campbell-mother 815 Mountain View Rd. Waynesboro, PA 17268 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Smithsburg Crematory 6-12-2007 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service License 1331 Eastern Blvd. North, Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) enalli /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed burial-transit Exami and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Por in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No P.0. the 9□Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, by 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy death? 1 ☐ Yes certificate 2 No 2□ No Division or Vital 25. Was case referre medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Mcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 251 & Antietam ST

3H-0

State Registrar

31. Date filed (Month, Day, Year) JUN 1 2 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

**ORIGINAL** 

07-04399

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

	urry 1-	S1 For State	tate of Maryla	and / Depai Certi	ificate of	Death			Reg. N	0		
Physician		gistrar Decedent's Name (First, Midd	dle,Last)					Mont	of Death th Da	y Ye	ear 3	. Time of Death 1834 hrs
Examine								June	e 8, 2007	4c. County	of Dooth	10041113
	4	a. Facility Name (if not instituti	ion, give street and n	umber)	41	b. City, Town, c		eath		Washir		
		WB ALT 40 E of Coo	l Hollow Rd			Boonsboro		le B	C Diete (b.		•	place (State or
Funeral	5	Social Security Number	6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Ye		Min			Foreign	
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th wi		1 X Never Married 2	Married Armed	Forces?	If Y	es, specify Cub	an, Mexican, P	uerto Rican,	etc.)	'   "	iito, oto.	
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hour hour Exau		Elementary/Secondary (0-1)		(1-4 or 5+)	during m	ost of working l	re. DO NOT us	e reureu)				
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5-0036 lied within 72 hours after death Hygiene. 1 other than "natural", or ite the Medical Examiner must	Completed	17. Father's Name (First, Midd	dle, Last)				18.Mother's			den Surna	me)	
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Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	8	19a. Informant's Name/Relation	onship (Type, Print )			g Address (St						, Zip Code)
shou and I		M/M MICHAEL CU		ENTS		5 MANOR			, BOON	SBORG	), MD	21713
Baltimore, MD permit Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumat		20a. Method of Disposition		20b.	Place of Dispos crematory or of	sition (Name of	cemetery,	Date	• 1	20c. Locati	on - City or	Town, State
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Pag ment tant:		4 Donation 5 Other	Specify:			Name and Add						
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ш ұды.	_	23a. Part . Enter the disease	Tor complications th	at caused the death	Do not enter	the mode of dy	ng, such as ca	rdiac or resp	iratory arres	t, shock, o	r heart	Approximate Intel
ysician		failure List only one car	use on each line.									Death
i al Examiner		Immediate Cause (Final dise	ease a Multiple		-f).							
LAdminor		or condition resulting in death	n) Due to (or a	as a consequence	or):							
	اير	Sequentially list conditions, if any, leading to immediate	Due to (or	as a consequence	of):							
	Ē.	cause. Enter Underlying Cau	use c.									4
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Box 68760 e death certificate the attending physed for use as the b	Physician/Me	23b. Was decedent pregnant past 12 months?		ive birth Pregnant at time of c		Fetal death		pregnancy				
ox 6 tth ce attend or use	ic.	1 Yes 2 No 9	17	Inknown	seath 5	Other (Specify)				-		
F 6 G G	چّ	Part II. Other significant co		ing to death but not	resulting in the	e underlying ca	use given in Pa	irt I.				to the cause of death
ned the me	by F	Part II. Other Significant Co	Marions continue	ing to country					1 Yes	2 🗸 No	3 Pr	obably 4 Unkno
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** James Tate Cockrill 12:40 P M June 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8107 River Crescent Drive Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Date of Birth (Month, Day, **Funeral** Months Days Hours **1** 2 □ F 429-16-3920 86 May 30, 1921 Arkansas Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show at Maryland r than "natural", or Items 23a or 28a-f sh the Medical Examiner must be notified Anne Arundel Annapolis 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8107 River Crescent Drive 21401 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates: 1944–68 1 Never Married XX Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 72 (Give kind of work done during most of working life. DO NOT use retired) De filed wh.

I Hygiene.

or than "r Elementary/Secondary (0-12) College (1-4or 5+) Captain U.S. Navy 5+ 12 should be filed w and Mental Hygier is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Thaddeus Cockrill Sara Irene Haden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State. Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once. Betty Farinholt Cockrill/wife 8107 River Crescent Drive Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 🏖 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 6/6/2007 Baltimore, Maryland 21. Signature uneral Se lice Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** (onges/ Ive disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ĮQ. in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) signed by the a P.0. 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed certificate 2 No 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 | Yes 2 → HO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 28c. Injury at Work? Certification: Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

State Registrar 29b. Signature and title of certife

31. Date filed (Month Day,

address of

JUN 0 6 200

Petonse

29c. License number

017965

Annapolis,

29d. Date signed (Month, Day, Year) 0"

and manner stated

person who completed cause of death (Item 23a) (Type, Print)

		State of Maryland / De	partment of Health and ertificate of Death		
		Registrar  1. Decedent's Name (First, Middle, Last)	erinicale or Dealir	Reg. I	
Physici		Joseph Francis Carroll		2. Date of Death  Month  June 6,	2007 Year 2,02 PM
/Medi Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	th	4c. County of Death
		2502 Catoctin Ct., Unit 1-D	Frederick		Frederick
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		8. Date of Birth	9 Birthplace (State or Foreign
Director		213-20-0579 1™ 2□F 80 Yrs.	William Days Tiodis William	Sept. 7, 1	1926 Maryland
pur v		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
laryla sho	5				1 X Yes 2 No
the M 28a-f iotifie	Director	Maryland Frederick Frede	erick	10-	
with a or	ā		10f. Zip Code		Citizen of What Country?
eath Is 23 musi	Funeral	2502 Catoctin Ct., Unit 1-D  11. Marital Status 12. Was Decedent Ever in U.S. 13	21702		nited States  14. Race - American Indian.
ter d	Ë	Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue</li> </ol>	rto Rican, etc.)	Black, White, etc.
Jrs at	β	1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No If Yes, Give WWII Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: White
2 hou satura	Completed		cedent's Usual Occupation	16b.	. Kind of Business/Industry
Pin 7	ple	(Specify only highest grade completed) (Gi Elementary/Secondary (0-12) College (1-4or 5+)	ve kind of work done during most of wo e. DO NOT use retired)	orking	
d with series of the series of	Ş		chinist		Manufacturing
al Hy soft	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Na	me (First, Middle, Maid	den Surname)
VICE:	ု	Joseph Francis Carroll, Sr.	Myrtle	Frantum	
Index yield C Z I S-0030 d 2 should be filed within 72 hours after death with the Maryland h and Mental Hyglene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at			illing Address (Street and Number or R		
and and ealth n 27			2 Catoctin Ct., Un		ederick, MD 21702
Ses 1		cemetery, c	position (Name of rematory or other place) Sthaven June		Location - City or Town, State
mit. Pages partment of cortant: If it in vorge.		4□Donation 5□Other (Specify) Memorial	Gardens	2007 Fre	derick, Maryland
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra		21. Signature of Euneral Gervice Licenses	22. Name and Address of Facility Resthaven Funeral	Services,	Skkot Codv P.A.
4 2 5 % 5		1///	9501 Catoctin Mtn.	Hwy. Fred	erick, MD 21701
		23a. Part. Ent. the dise s., or complications that caused the death. Do not e shock, or leart failure. List only one cause on each line.	enter the mode of dying, such as cardia	ac or respiratory arrest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	nt esop.	hencient	Onset and Death
/Medical		resulting in death)  Due to (or as a consequence of):			
Examiner	_	Sequentially list conditions, b.			
sit 9d	iner	Sequentially list conditions, if any, leading to immediate cause. Ener underlying Cause (Disease or injury			
ecute and tran	Examin	that initiated events resulting in death) Last  C			
be executed sician and burial-transit		Due to (or as a consequence or).			
the state	dical	d			
death certific attending p	Physician/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy		·	
atten for us	ian	in the past 12 months?	B ☐ Ectopic pregnancy D ☐ Other (specify)		23d. Date of delivery  Month Day Year
at the de by the	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	D Other (specify)		
res that signed by be deta		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
uires sign ld be	d by	400M, 45(UD, 1	property	1 ☐ Yes	2 No 3 Probably 4 Unknown
w require	ete			24a. Was an	Odb Wassacks of Salisan wellship
he lay has ge 2	Completed			autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
hysician: The law his certificate has I director, page 2 s		OF Was seen referred to an discl		1□ Yes 2☑	
sicia certi recto	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No		ath (Check only one)	
Phy Printer of the Pr	: To	1		Home 5 Residence	
ding h. After funer	tion	1 ☑ Natural 5 □ Pending (Month, Ďay Year) Injur 2 □ Accident investigation	e of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
deat deat ctor	fica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm,		28f. Location (Street	and Number or Rural Route Number.
affer affer d in b	Certification:	4 ☐ Homicide determined building, etc. (Specify)	•	City or Town, St	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director;		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place	e, and due to the cause	e(s) and manner as stated.
ne Ho ne Fu ne Fu	edical	(Check only one) 2 ☐ <b>Medical Examiner:</b> On the basis of examination and/or and manner stated.	investigation, in my opinion, death occ	curred at the time, date a	and place, and due to the cause(s)
To th Withir To th	Me	29b. Signature and title of certifier	29c. License number	29d. [	Date signed (Month, Day, Year)
~		2 Zel	11462	C 5.	UNZ 8 2007
1/2/1/1/		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)		9/761
M.		DG Placosch My	501 an	C3 5C	Date signed (Month, Day, Year)  UNC 8, 2007  Freding Mg
Sta	- 0	31. Date filed (Month Day Year) 8 2007 32. egistrar's Signature	had ,		
Registr	ar	2011 0 0 2001 Japanes 10-			

			1 - State Amend Items 23a per d	land / [ <b>r.,g</b> 8/	6 Cer	<b>8701707a</b> tificate of	lealth ar <b>hb</b> Death	nd Mei	ntal Hygid	ene 200	7 20118
F	750		Decedent's Name (First, Middle, Last)					2.	Date of Death		3. Time of Death
г	Physici /Medic		Darkne Cordrey					(	Month	O 5 acc	7 0117 AM
	Examin		4a. Facility Name (If not institution, give street and number)			4b. City, Town, or	Location of			4c. County of D	eath
1			University of Haryland Hedical	Syste	m	Baltin	nore			Baltimor	e City
	Funeral		5. Social Security Number 6. Sex 7. Age (II	n yrs. last biri	- 1	If Under 1 Year Months Days	If Under 24	4 Hrs. 8. Min.	Date of Birth (Month, Day, 1		Birthplace (Stale or Foreign Country)
	Director		213–42–0302 <sup>1□M 2</sup> ▼ 63	3	Yrs.				(Month, Day, 1 7/4/194	3 M	aryĺand
	and		Usual Residence of Decedent           10a. State         10b. County         10	c. City, Towr	or Loc	ation					10d, Inside City Limits
	Many f sho	호	Maryland Wicomico	Salis	bur	v					1 □ Yes 2 → No
	the 128a	irec	10e. Street and Number			10f. Zip Code			109	g. Citizen of What	Country?
	h with	Funeral Director	509 Archer Place			2180	4			USA	
	death	ner	11. Marital Status 12. Was Decedent Eve Armed Forces?	r in U.S.	13. V	⊥ √as Decedent of H Yes, specify Cuba	ispanic Origin	n? (Specify	/ Yes or No-		merican Indian,
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland not Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	y Fu	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No If Yes, Give			Yes 2 XNo	Specify:	ruello Nic	an, etc.)	Black, W Specify:	white
Ö	hour tural' al Ex	Completed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education	169	Deced	ent's Usual Occup	ation		1.0	1	
7	in 72 "na" r	olete	(Specify only highest grade completed)	Toa.	(Give F	kind of work done o O NOT use retired	durina most a	of working	1 1/27	3b. Kind of Busine	ss/industry
712	e filed within al Hygiene. I other than " vent, the Mer	E	Elementary/Secondary (0-12) College (1-4or 5+)	т	'eac		,			Education	n
b	il Hygi other ent, tl	Be C	17. Father's Name (First, Middle, Last)				18. Mother's	s Name (F	irst, Middle, Ma	aiden Surname)	
Maryland 21215-0036	should be and Mental second marked output umarked output umarked output eve	To B	Loran Howard Morris				Mary	Eliz	abeth V	Vainwrigh	nt
Nar	2 sho and l		19a. Informant's Name/Relationship (Type. Print)							City or Town, State	
	s 1 and 2 of Health a item 27 Is other trau		Howard L. Cordrey/husband  20a. Method of Disposition			ition (Name of	riace,	Date		MD 21804	
altimore,	ages nt of I		1 ★Burial 2 Cremation 3 Removal from State	Wicom:	ry, crem	Memorial	re)		-		
Itin	iit. Partmen		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee		Park		10/	/8/07		Salisbur	
Ba	permit. Pages 'Department of HIMportant: If ite any Injury or of once.		Kold M Lawrey (FSt	2	-1	10110Way 501 Snow	Funera Hill F	al Ho	me Prof Salisbu	essional ry, MD 2	Association 1804
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do r	not ente	r the mode of dyin	g, such as ca	ardiac or re	espiratory arres	t,	Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	ric S	ho	X					Onset and Death
	/Medical Examiner		Due to (or as a co	onsequence o	of):						
		-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a co	2 Diab		S					
	uted insit	Examiner	cause. Enter Underlying	tensio							
Ć	execin and ial-tra	Exa	resulting in death) Last  Due to (or as a co						<u> </u>		
8760,	cate be executed physician and the burial-transit	dical	d. Breas	t Canc	er						
Θ	ing pl	Med	IF FEMALE:								
Вох	death certific e attending p d for use as	lan/	23b. Was decedent pregnant 23c. If yes, outcome print		3□	Ectopic pregnancy	,			23d. Date of Month	delivery Day Year
o.	0 0 0	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	e of death	5 🗆	Other (specify)		-,		Month	Day Feal
<u>α</u>	that the de led by the a detached	F	Part II. Other significant conditions contributing to death but no	ot resulting in	the un	derlying cause give	en in Part I		23e. Did toba	cco use contribute	to the cause of death?
Vital Records,	es De pe	d by		<b>-</b>		,g g			1 ☐ Yes	-7	Probably 4 ☐Unknown
CO	w requir been si should	Completed						- 11	24a. Was an		autonou findingo available
Re	he lay e has ige 2	E D						-	autopsy performe	prior death	autopsy findings available to completion of cause of ?
ā	in; T ificate or, pa	ပ္	25. Was case referred to medical				00 Di	(D#- (0		No 1□Y	es 2 No
>	Physician; this certific ral director,	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient	2 ☐ ER/Out	tnatient	3 □ DOA Othe	or.		heck only one)	ce 6 □Other (S	and it is
0	g Phy er this eral c	n: To	27. Manner of Death 28a. Date of Injury	28b. T	ime of	28c. Injur				injury occurred	оеспу)
Division or	Attending r death. ector: After by the fune	ați	1 Natural 5 □ Pending (Month, Day Ye 2 □ Accident investigation	<i>ear)</i>   Ir	njury		<br Yes 2 ☐ No	D			
Vis	Atte	III C	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury building, etc. (5	- At home, far	rm, stre	et, factory, office		28f.	Location (Stre City or Town,		Rural Route Number,
Ö	Ital or rs afte ral Dil	Certification:								·	
	To the Hospital or Attending Physician: The law within 24 hours after death.  Jo the Funeral Director After this certificate has gompletely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of many one and manner stated	amination and	, death d/or inv	occurred at the tin estigation, in my o	ne, date and pinion, death	place, and occurred	due to the cau at the time, dat	ise(s) and manner e and place, and o	as stated. lue to the cause(s)
	To the within	Me	29b. Signature and title of certifier			29c. License	number		290	I. Date signed (M	onth, Day, Year)
	7/3		V DOWN M.D.			199	895			06 05	2007
	100		30. Name and address of person who completed cause of death	_		1					
	10				e S	heet Bo	11timore	e, MD	9190	1	
	Sta Registr	_	31. Date filed (Month, Day, Year) 32. Registrar's	oignature		122					
	, rogioti		JOH O O ZOUT STEPLES	S		W					

Physician

/Medical

Examiner

**Funeral** 

Director

"natural", or itsms 23a or 28e-f show

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Heelih and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iten any injury or other traumatic svent, Ite Madical Exami

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

Be

death with the Maryland

Division of Vital Records, P.O. Box 68760.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect Due to (or as a consect d.				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 □Ectopic			23d. Date of delivery Month Day Year
Part II. Other significant conditions of	contributing to death but not re-	sulting in the underlying	g cause given in Part I.	23e. Did tobacco t	use contribute to the cause of death?
				24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
25. Was case referred to medical			26. Place of De	ath (Check only one)	
examiner? 1 ☐ Yes 2 ZÃNo	Hospital: 1 ☐ Inpatient 2 ☐	☐ER/Outpatient 3☐	OOA Other: Nursing	Home 5 ☐ Residence	6 □Other (Specify)
27. Magner of Death   Natural 5 Pending   Page 1   Pending   Pendi	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur	y occurred
3 Suicide 6 Could not b 4 Homicide determined		nome, farm, street, fact ify)	ory, office	28f. Location (Street are City or Town, State	d Number or Rural Route Number, )
29a. Certifier Check only one) Check only	nysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date and place on, in my opinion, death occ	ee, and due to the cause(s curred at the time, date and	and manner as stated. d place, and due to the cause(s)
and all a sections of section of		1,	NO. Lisance sumber	20d De	to sinced (Manth Day Vees)

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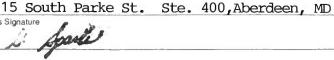
State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Prashant Shukla, MD 3 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



1 - For State Regis	, 1000	State of M		i / Depa		t of H	ealth a		ental Hy	. 211	17	201	211
	ntrar nt's Name <i>(First, Middl</i> e, La <i>s</i> i	)			uncare	OIL	- au i	1	2. Date of Dea	Reg. No.		3. Time of	Death
Physician			rummit	t					June 17	Davi	Year	8:45	
/Medical	Name (If not institution, give den Living Nu	street and number	ne			Town, or	Location o	f Death		4c. County	of Death		
Director 217-2		х Эм <b>Ж</b> Т 7. А	ge (In yrs. Ia. 92	st birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt Month 29	, Yell 915	9. Births	place (State of	r Foreign
2		ek		Town or Lo lerick								10d. Inside Cit	
10e. Street	t and Number 03 Quinn Road				10f. Zip	Code 21 <b>7</b> 01				10g. Citizen of U.S	What Cou	ntry?	
Inyland 21215-0036  should be filed within 72 hours after death with the Maryland of Mental Hygiene  marked other then "neturet," or Items 23a or 28e-f show mattic event, it Medical Erain with the Maryland  To Be Completed by Funeral Director  11. Wedical Erain with the Maryland  To Be Completed by Funeral Director  12. Eather  13a' Puton  14a' Funeral Director  15a' Funeral Director  15	Status  ver Married 2 Married  dowed 4 Divorced	12. Was Deceden Armed Forces 1 Tyes 2 P If Yes, Give Year or Dates	:? ] No	i	Vas Deced Yes, spec	V	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto I	ocify Yes or No- Rican, etc.)		ce - Americ ck, White, y: Wh		
Baltimore, Maryland 21215-0036  Bermit. Pages 1 and 2 should be liled within 72 hours at Department of Health and Mental Hygiene.  Importent: If item 27 1s marked other then "neture!, or any injury or other treumatic event. It. Medical Frair. pnce.  To Be Completed by F 3 item 27 is any injury or other treumatic event. It. Medical Frair. pnce.  To Be Completed by F 3 item 27 is any injury or other treumatic event. It. Medical Frair. pnce.  To Be Completed by F 3 item 27 is any injury or other treumatic event. It. Medical Frair. pnce.	15. Decedent's Edu (Specify only highest grad	ication e completed) College (1-4or	5+)		lent's Usua kind of wor DO NOT us memak	rk done di e retired)	tion uring most	of workii	ng	16b. Kind of B		dustry Iome	
F 0 = 0 5 1 3	s Name <i>(First, Middle, Last)</i> John Berna	ard Hurst								Maiden Suman nce Gru			
Mary Mary 19a. Information 19a. Informat	nant's Name/Relationship (T) and R. Crummit									or, City or Town, D 21701	State, Zip	Code)	
Baltimore, Marylar  permit. Pages 1 and 2 should by Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic a- none.  Solution  To B  To B	od of Disposition urial 2 Cremation 3 F onation 5 Other (Specify)	Removal from State	20b. Pla Mour	of Dispon The Oliv	sition (Name natory or of et Cem	ne of ther place etery	June	21,	ate 2007	Frede			
Demail Departing any initial police.	ore of Funeral Service Licens		MO0255	Ke	Name and eeney	and st Cl	Basi lurch	ord St.	PA Fune	eral Hon	ne ID 21	701	
Physician /Medical Examiner  Sequentia if any, lea	lly list conditions, ding to immediate iter Underlying	Due to (or a	ine.  O N s a conseque s a conseque	Cnw ence of):	er the mode		, such as o	cardiac o	r respiratory ar	rest,		Approximate Interval Betw Onset and D	veen
te be but le but	F: (	d.	s a conseque							23d Da	te of delive	arv.	
S, P.O. BOX 68 es that the death certifica gned by the attending ph be detached for use as it by Physician/Med  By Physician/Med  By Physician/Med  Control  By Physician/Med	past 12 months? res 2/2/No Jinknown	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown			Ectopic pre Other (spe					40.	enth		ear
	er significant conditions co	ntributing to death	but not result	ing in the ur	iderlying ca	iuse giver	n in Part I.			obacco use cont res 2 □ No	ribute to tl 3 ☐ Prob		nknown
The law The law ate has b page 2 si					<del>_</del>			·	24a. Was autop perfor	med?	prior to co death?	psy findings a mpletion of ca 2 No	
25. Was c	ase referred to medical	lospital:						of Death	(Check only o	ne)			
F E SE L	15 21 NO	1 🗀 Inpat		R/Outpatient		A Other	4 Junur			lence 6 Oth		y)	
nding ath.	tural 5 Pending	28a. Date of Inj (Month, D	ay Year)	Injury	M	Work'			od. Describe i	ow injury occur	100		
IVIS or Atta in acto or by th or by th H□ 7		28e. Place of Ir building, e	njury - At hom atc. <i>(Specify)</i>	e, farm, stre		_			8f. Location (S City or Tow	Street and Numb n, State)	er or Rura	l Route Numb	oer,
<b>d</b> 0 € € 7 29a. Certi	ier 1 Certifying Phy k only 2 Medical Exami	sician: To the bes ner: On the basis and manner s	of examinatio	ledge, death on and/or inv	occurred a restigation,	at the time in my opi	e, date and inion, deat	d place, a	and due to the ded at the time, d	cause(s) and ma date and place,	inner as s and due to	tated. the cause(s)	
The state of the s	iture and title of certifier	10				License D		51		June 1			
30. Name	and address of person who co	mpleted cause of	death (Item 2	23a) (Type, 1	Print)	US E	Ave	. Fr	LEDERIC	k M	2 2	1701	,
	JUN 29, 1°2007	ompleted cause of	trar's Signatu	re d									

				se Type or Prin State of Ma					-			22101
			1 - For State Registrar				rtificate of			Reg. No.		20121
+	Physic /Medi		1. Decedent's Name (First, Middle.  James		Dixon				2. Date of De Month May 2	Day	2007	3. Time of Death 6:20A M
ia.	Exami		4a. Facility Name (If not institution,				4b. City, Town, o	or Location of Deat	h	4c.	County of Dea	th
17			Chesapeake W	oods Center			Cambri	dge			Dorche	ester
	Funeral		5. Social Security Number	6. Sex 7. Ag 1 ☑ M 2 ☐ F	e (In yrs. last b		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	rth ay, Year)	9. Bir	thplace (State or Foreign
4.4	Director		215-16-0264	TXX M ZUF	85	Yrs.			Feb. 6		22 u	nknown
_	n the Maryland r 28a-f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD Dorch	ester	10c. City, To	wn or Lo		ridge				10d. Inside City Limits  Marie Yes 2 □ No
5	or 28a	Funeral Director	10e. Street and Number		1		10f. Zip Code			10g. Citi	izen of What Co	ountry?
}	ath v	-a	525 Glenburn A					1613			USA	
36	within 72 hours after death with the Maryland ene. than "natural", or Itema 23a or 28a-f show than Madigal Exem or court or confiled at	2	11. Marital Status  1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces?  1 X Yes 2 1 If Yes, Give Year or Dates:	No		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2½ No	Hispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No to Rican, etc.)	0-	14. Race - Ame Black, White Specify: Wh	te, etc.
Ş	72 hours "natural",	ted	15. Decedent		168	a. Dece	dent's Usual Occup	pation		16b. Ki	ind of Business	/Industry
21215-0036	f within 72 ho pene. r than "natu	Completed	(Specify only highest	completed) College (1-4or 5	5+)	life.	kind of work done DO NOT use retire Truck dri	*	rking	tr	ansport	ation
N	Hygi ther int,		17. Father's Name (First, Middle, L	ast)				18. Mother's Nar	ne (First Middle			
ă	of it b	Be	unknown	,				unknowr		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ouumo/	
2	2 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	2	19a. Informant's Name/Relationsh	in (Type Print)	10	h Mailir	ng Address (Street	and Number or Ru		os Cibro	r Tour State	Zin Codo)
-	tra tra	1 8	James Dixon Jr					3, Hanove			_	zip code)
	Heal Heal em 2		20a. Method of Disposition	• 2			osition (Name of matory or other pla		Date	2107	ocation - City or	Town State
saltimore,	Pages ment of ant: If It ury or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		i		matory or other pla y Cremato	1	2/07		sbury,	
		1	21. Signature of Funeral Service L		Daris		-	ess of Facility Th	-			
ñ	permit Depart Import any in		1 SER					t St., Ca				
15			23a. Part1. Enter the disease, or o	complications that caused	the death. Do						21013	Approximate
	) Dhysisian		shock, or heart failure. List of Immediate Cause (Final			1						Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	a. Myoc	crue	2 01):	marc	7107			<	1 a > 4
ø.	Examiner			Coron	a consequence	arta	infarci ery dis	Pace				254 HAS
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a co Juence	of):	1	C41				70 / 60 /
	be executed sician and burial-transit	Examin	Cause (Disease or injury that initiated events									
a"	be executed ician and burial-transit	Exa	resulting in death) Last	Due to (or as	a consequence	of):						
	te be ysicia e bul	cai		d								
Ω	intica g ph as th	edi		1								
	es that the death certificate igned by the attending phys be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal deat		Ectopic pregnanc Other (specify)	у			23d. Date of de Month	livery Day Year
<b>T</b>	that		Part II. Other significant condition	ns contributing to death b	ut not resulting	in the u	nderlying cause giv	ven in Part I.	23e. Did	obacco u	ise contribute to	o the cause of death?
SD	requires that the een signed by th hould be detache	d by	chronic obs	structive	pulmo	na	ry dis	ease	1 🗆	Yes 2	2000 3 □ P	robably 4 Unknown
ecord	> Q TO	Completed	Cardiomyor	,					24a. Was	an	24b. Were a	utopsy findings available
e i	e e fa has e 2	E G		-Crity					auto		prior to death?	completion of cause of
	ician: Ih certificete rector, pag	CO	dementi 2  25. Was case referred to medical					60 PL (D)	1 Yes	20 No	1 L Yes	2 No
	Physician: this certific al director,	OB	examiner?  1 Yes 2 No	Hospital:	ont 2□ ER/C	Vutaation	nt 3 DOA Ott	26. Place of Dea	lome 5 ☐ Resi			
		<b> </b>	27. Manner of Death	28a. Date of Inju	ry 28b.	Time of	f 28c. Inju	ry at	28d. Describe			icity)
5	th. : Afte	tior	1 Natural 5 Pending 2 Accident investiga		y Year)	Injury	Wo	rk? ∣Yes 2∐No				
DIVISION	Attending r death. ector: After by the funer	ertification:	3 Suicide 6 Could not	ned   286. Place of Inju	ury - At home, i	farm, str	reet, factory, office		28f. Location (	Street an	d Number or R	ural Route Number,
5	safte safte al Dir	Cert	4   Hornicide	building, et	c. (Specify)				City or To	wn, State	)	
:	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical (	29a. Certifier Check only one) Certifying	Physician: To the best examiner: On the basis of and manner sta	f examination a	ge, deatl ind/or in	h occurred at the ti vestigation, in my	me, date and place opinion, death occu	e, and due to the irred at the time,	cause(s) date and	and manner as I place, and due	s stated. e to the cause(s)
	omple omple	Me	29b. Signature and title of certifier				29c. Licens	se number		29d. Dat	te signed (Moni	th, Day, Year)
) '	->=0		Manso	en aso			Hoe	259973		5/5	20/10-	7
			30. Name/and address of person v	yho completed cause of d	eath (Item 23a)	Туре,	Print)	St C	mh	10=	111	216/3
	- 1 - F-		Patricia Ja	ohnson	100 1	110	MOLE	er, car	TOPIC	rye	1910	21613
	Sta	ate	31. Date filed (Month, Day, Year)	4 2007 32. Reg	ar's Signature	K	Angell 1					

# Please T

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	Pleas	se Type or Pri		<b>c indelible in</b> legation				Die.		
		State of M		Certificate of			g. No.	107	20122	
1. Decedent's Nam	e (First, Middle,	Last)				2. Dete of Deet Month	h Dey	Year	3. Time of Death	
Eunice	e M. Do	onivan				June 7	2007	7	22:45	
4a Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of Deeth  4c. County of Deeth										
C.J. Se	enior (	Care Cent	er		Hagers	town	Wash	ingt	on	
5. Social Security N 236 – 58 -		6. Sex 7. As 1  M 2  F	ge (In yrs. last birtl 84 Y	hday) If Undar 1 Yea Months Day		. (Month, Day,	Year) 1922	9. Birthr Cou	place (State or Foreign ntry)	
Usuel Residence of	Decedent									
10a. Stete	10b. County		10c. City, Town	or Location					10d. Inside City Limits	
MD	Wash	ington	Hage	rstown					Yes 2□No	
10e. Street end Nu	mber			10f. Zip Code		11	0g. Citizen of	What Cou	ntry?	
147 F	King St	treet		217	40		USA			
11. Marital Stetus 1 ☐ Never Marr 3 ☑ Widowed		12. Was Decedent Armed Forces' ed 1 Tyes 247 If Yes, Give A Year or Detes:		13. Was Decedent or If Yes, specify Cu 1 ☐ Yes 25 N		Specify Yes or No- rto Rican, etc.)	Bla	ce - Americk, White,		

29d. Date signed (Month, Day, Year)

6-11-07

147 11. Marital Stetus 1 Never Married 2 Married 3 Widowed 4 ☐ Divorced

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or items 23s or 28s-f show any injury or other treumstic event, "In Medical Examiner must be notified at **Funeral Director** Be Completed by

Baltimore, Maryland 21215-0020

**Physician** 

/Medical

Examiner

**Funeral** 

Director

**Physician** /Medica Examine

within 24 hours effer death.

To the Funerel Director: After this certificate has been signed by the attending physicien end completaly fillad in by the funerel director, pega 2 should be detached for use es the buriel-transit

Medical Certification:

State

Registrar

29a. Certifier

29b. Signature and title of certifier

31. Dete filed (Month, Day, Year)

2AR

JUN 1 1 2007

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

AF

32. Registrar's Signature

To the Hospital or Attending Physician: The law requires thet the death certificate be axecuted Division of Vital Records, P.O. Box 68760,

	Dand
	23e. Part1. Enter the di shock, or heart fai
	Immediate Ceuse (Fina disease or condition resulting in death)
■ VMedical Examiner	Sequentially list condition of the condition of the cause. Enter Underlying Ceuse (Disease or injurthet initiated events resulting in deeth) Lest
Completed by Physiclan/Medical Examine	Pert II. Other significan
To Be Com	25. Was case referred to examiner?
1.2	and a december of the sale

15. Decedent's I (Specify only highest g	rade completed)	(Gi	cedent's Usual Oc ve kind of work do b. DO NOT use re	16b. Kind of Bu	siness/Industry			
Elementery/Secondery (0-12)	College (1-4or 5+)		omemake			Home	е	
17. Fether's Neme (First, Middle, Las	st)			18. Mother's Na	me (First, Middle,	Maiden Sumam	ө)	
Harry Clint	on Gray, Sr.			Estel1	a R. Ho	offman		
19a. Informant's Name/Relationship			iling Address (Str	eet and Number or R	ural Route Numbe	r, City or Town,	State, Zip Code)	
James R. Don	ivan,Jr./So	n PO	Box 262	,Shenand	loah Jur	nction	WV 255	342
20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	☐Removal from State	b. Place of Dis cemetery, c	position (Name or rematory or other		Date	20c. Location -	City or Town, Sta	ate
21. Signature of Funeral Service Lie	tolar plat H MG.	1035	22. Name and Ad	dress of Facility Me Fairfax	elvin T.			
23e. Part1. Enter the diseese, or co shock, or heart failure. List onl	mplications that caused the d y one cause on eech line.						Approx	ximate al Between and Death
Immediate Ceuse (Final disease or condition resulting in death)	· alz	bem	in a	liscose			20	lows
,	Duer	o (or as a cons	sequence of):	Thure	,		5	months
Sequentially list conditions, if eny, leeding to immediate	Due t	o (or as e cons	sequence of):					
cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest	cDue to	o (or as a cons	equence of):					
	d						-	
Pert II. Other significant conditions	contributing to death but not	resulting in the	underlying cause	given in Pert I.	23b. Did to	obacco use cor	tribute to the ca	uee of death?
					101	/es 2□No	3 Probably	4/△Unknown
					24a. Wes e	en autopsy med?	24b. Were auto available j completio of death?	prior to on of cause
					151	es 21/200	1 ☐ Yes	21 No
25. Was case referred to medical examiner?					ath (Check only o	ne)		
1 ☐ Yes 2 D No	Hospital: 1 Inpatient	2 ER/Outpat	tient 3 DOA	Other: 4 Nursing I	Home 5 Resid			
27. Manner of Deeth 1 □Naturel 5 □ Pending 2 □ Accident investigati	28e. Date of Injury (Month, Day Year	r) 28b. Time Injur	y	njury et Work? 1 □ Yes 2 □ No	28d. Describe h	ow injury occurr	ed	
3 Suicide 6 Could not determine	be 28e. Plece of Injury - A	At home, farm,	street, factory, off	ice	28f. Location (S	treet and Numb	er or Rural Route	Number,

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner es steted.

Hedical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29c. License number

D28365

368 nulls Street-Hagartonn 190 21740

DHMH 16 Rev 6/95

			State of Ma	ryland /	-	rtment of He		lental Hy	giene	0005	00:00
			Registrar  1. Decedent's Name (First, Middle, Last)		Cer	tificate of D	eatn	2. Date of De	Reg. No.	2001	3. Time of Death
	Physicia	ın	Fermina Tablizo	Ding	gal			Month DG-	Day	Year 2007	
	/Medic Examin		4a Facility Name (If not institution, give street and number)			4b. City, Town, or L	ocation of Death	04-		County of Death	
	LXuiiiii	G1	PENINSULA REGIONAL MEDICAL	. CENT	でん	SALISB	URY		W	comic	8
	Funeral		5. Social Security Number 6. Sex 7. Age	e (In yrs. last i	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	y, Year)	Cou	nplace (State or Foreign untry)
-	Director		214-11-2539 Usual Residence of Decedent	89	TIS.			5/20/	1918	Ph	illippines
	ow at	ŀ	10a. State 10b. County	10c. City, To	own or Loc	eation		i			10d. Inside City Limits
	a-f sh ified	itor	Maryland Wicomico	Sali	sbury	Y		4			1 ☐ Yes 2 <b>X</b> No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Co	untry?
	ath w	ral	316 Brewington Drive		40.14	21801		-if Ves - Ne	USA	4. Race - Amei	ican Indian
	within 72 hours after death with the Maryland ene. than "hatural", or items 23a or 28a-f show the Medical Examiner must be notified at	Funeral	11. Marital Status  12. Was Decedent I Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ 1		13. V	Vas Decedent of Hisp Yes, specify Cuban	, Mexican, Puerto	Rican, etc.)	~	Black, White	
330	urs aff	by	3 Widowed 4 Divorced Year or Dates:		1	☐ Yes 2 No	Specify:			Specify: Ph	illippino
2-003p	72 hor	Completed	15. Decedent's Education (Specify only highest grade completed)	16	6a. Deced	ent's Usual Occupat kind of work done du DO NOT use retired)	ion rina most of worki	ina	16b. Kir	d of Business/l	ndustry
7	/Ithin ne.	du M	Elementary/Secondary (0-12) College (1-4or 5	ı+)	`life. D	OO NOT use retired)	5	5			
7	Hygie Hygie ther th		17. Father's Name (First, Middle, Last)		Home	maker 1	8. Mother's Name	e (First, Middle,		mestic	
and	d be f ental l ced of	To Be	Aguido Tablizo					adia Nav		,	
ary	shoul nd Me mark	ř	19a. Informant's Name/Relationship (Type. Print)	1	19b. Mailin	g Address (Street ar					Tip Code)
Ĕ	and 2 alth a 27 is er trai		Patrick Henry/son		316	Brewingtor	n Dr., Sa	alisbur	y, MI	21801	
ore	of He fitem		20a. Method of Disposition 1 ☐Burial 2 ☐Cremation 3 ☐Removal from State	20b. Place ceme	e of Dispos etery, cren	sition (Name of natory or other place)	)	Date	20c. Loc	cation - City or	Town, State
Ē	Pag tment tant: I		4 ☐Donation 5 ☐ Other (Specify)	Pars		Cemetery	6/9/			isbury	
baitimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Department of Health and Mental Hyglene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service License	AP	22	Name and Address Holloway 501 Snow	Funeral Hill Rd.	Home Pr , Salis	ofes	sional , MD 21	Association 804
	700		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each I	he death. D	Do not ente	er the mode of dying.	such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death) a.	WE	1	017	1811	Kin	7		Onset and Death
	/Medical Examiner		Due Tr	a consequent	ce of):			1			
		ē	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	а сопрецист	ee uf):			-			
	d d ansit	Examine	Cause (Disease or injury that initiated events								
Ď,	cate be executed physician and the burial-transit	EX	resulting in death) Last Due to (or as	a consequent	ce of):						
09/80	cate b	dical	d								
9	certific ding p	/Me	IF FEMALE: 23c. If yes, outcome	of pregnancy	,					3d. Date of del	ivon
X P P	The law requires that the death certifite has been signed by the attending tage 2 should be detached for use as	Physician/Me	in the past 12 months?	2 Fetal de	ath 3□	Ectopic pregnancy Other (specify)				Month	Day Year
<u> </u>	the d by the ached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown								
ν, J	s that gned k	by P	Part II. Other significant conditions contributing to death b	ut not resultin	ng in the ur	nderlying cause giver	in Part I.	23e. Did 1	obacco u	se contribute to	the cause of death?
ğ	equire en sig ould b	ted	(-(10)-14)					10	Yes 2[	]No 3∏Pr	obably 4 Unknown
Vital Records,	law r las be	Completed	CAD.					24a. Was auto	DSV	prior to o	topsy findings available completion of cause of
<u> </u>		Son	C. dry Colins	)				1□ Yes	2 No	death? 1 ☐ Yes	2 No
<u> </u>	sician certifi rector	Be	25. Was case referred to medical examiner?  1  Yes 2  Hospital: Hospital:		/O. t tis	Other	26. Place of Deat			Пои (а	
Ö	Physer this eral di	: To	27. Manner of Death 28a. Date of Inju	iry 28	Outpatien  Bb. Time of		4 □ Nursing Ho at	28d. Describe			сіту)
<u>o</u>	nding tth. r: Afte e fune	atior	1 Natural 5 □ Pending (Month, Da 2 □ Accident investigation	y Year)	Injury		es 2 □ No				
Division	r Atte er dez recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of inj building, et	ury - At home c. (Specify)	e, farm, stre	eet, factory, office		28f. Location ( City or To			ural Route Number,
Ξ	ital o Irs aft ral Di Iled in										
	24 hou Fune stely fi	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner street.	or my knowle if exemination ated:	age, death and/or in	n occurred at the time vestigation, in my op	e, date and place, inion, death occur	and due to the red at the time	cause(s) , date and	and manner as place, and due	s stated. e to the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,	Mec	29b. Signature and title of certifier	7-7-		29c. License				e signed (Mont	
	00		*((\lank)	1 1	NI	$0 \mid 0$	- [7	611	6	16/0	1
•	Lan		30. Name and address of person who completed cause of d	leath (Item 23	Ba) (Type,	Print)				2	_/
	6		Razi Khan, M.O.	rar's Signature	CAKI	eo11 51.	SALI	ssyry	NU	)	
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registr	rar's Signature	, 1	and a		-			
	riogisti	-10	JUN V O ZUUI	u D	· Add						

	•	State of Maryland / Department   State of Maryland / State of Maryland / State of Maryland   State of Maryland / State of Mar	artment of Health and Martificate of Death		iene eg. No. 2012h
Physicia	 an	Decedent's Name (First, Middle, Last)     Kathryn Virginia EBERSOLE		2. Date of Deat	h Dal Year 7
/Medic Examine	al.	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	JOIN	4c. County of Death
		Fahrney-Keedy Home  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Boonsboro If Under 1 Year   If Under 24 Hrs.	8 Date of Birth	Washington
Funeral Director	9	212-24-7158 1□M 2⊠F 80 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, March 1	Year) 9. Birthplace (State or Foreign Country) Maryland
/land		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Lo.	cation		10d. Inside City Limits
e Man	Director	Maryland Washington Hagers			1 ☑ Yes 2 ☐ No  Og. Citizen of What Country?
with the		10e. Street and Number 905 Kenwood Drive	10f. Zip Code 21740	1	USA
death ms 23	Funeral	11 Morital Status 12 Was Decedent Ever in U.S. 13.1	Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - American Indian, Black, White, etc.
Baltimore, Maryland 21215-0036 perrit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tien 27 is marked other then "naturel", or items 23e or 28e-f show any injury or other treumatic event, the Madical Examitment as notified at once.	by Fur	1 Never Married XXMarried 1 Yes 2 No	1 ☐ Yes 2 ☑ No Specify:	o riloan, oto.,	Specify: white
Maryland 21215-0036 d 2 should be filed within 72 hours affith and Mantal Hygiens 77 Is marked other then "naturel; or treumatic event, the Madical Examples."	Completed by	15. Decedent's Education (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of wor DO NOT use retired)	king	16b. Kind of Business/Industry
2121 d within giene.	Somp	Elementary/Secondary (0·12) College (1·4or 5+) Cash	ier		retail sales
and The file Intal Hy ed oth	Be	17. Father's Name (First, Middle, Last)  Martin Kelly Sr.		ne (First, Middle, I tle Symo	
aryla should nd Me mark mark	P_C		ng Address (Street and Number or Ru		
, Ma and 2 salth a			3 Wicomico Ct., S		
Ore ges 1 it of He or oth		1 ★ Burial 2 □ Cremation 3 □ Hemoval from State	matory or other place)		20c. Location - City or Town, State
Baltimore, perrit. Pages 1 at moportness in the moportees: If them any injury or othe ang.	1		en Cemetery   6/1 2. Name and Address of Facility MI		Hagerstown, Maryland NERAL HOME
Department of the percent of the per	1		15 E. Wilson Blvd		
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on a ch line.  Immediate Cause (Final	ter the mode of dying, such as cardiac	or respiratory arr	Onset and Death
Pnysician /Medical		disease or condition resulting in death)  a  Due to (or as a consequence of):	:		2°
Examiner		Sequentially list conditions, b. Demonstrate			57
ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enser uncerying Cause (Disease or injury			
'60, be executed sician and burial-transit		that initiated events c.  Due to (or as a consequence of):			
18760, cate be exphysician at the burial	dical	d			
Box 61 Bot certific attending p for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 I	□Ectopic pregnancy		23d. Date of delivery  Month Day Year
P.O. E that the dea	ysich	in the past 12 months?  1  Yes 2	Other (specify)		,
S 8 8 8	by	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.		bacco use contribute to the cause of death?  Yes 2 □ No 3 □ Probably 4 ☑Unknown
ord ord require	eted			24a. Was a	/
Rec Rec The law te has I	ompleted			autop: perfor	sy prior to completion of cause of
Y Vital Reysician: The sis certificate his director, page	BeC	25. Was case referred to medical examiner?		ath (Check only or	ne)
of V Physic this or	은	1	The second secon		ence 6 Other (Specify) ow injury occurred
T gu agu	ation	11 Matural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 □ Yes 2 □ No		
Division of Division of Division of Division of Steel or Attending Four steel death.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (S City or Tow	Street and Number or Rural Route Number, vn, State)
Hosa 14 ho Fund fely f	edical Ce	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, dea 2 Medicel Exeminer: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place evestigation, in my opinion, death occ	e, and due to the curred at the time, o	cause(s) and manner as stated. date and place, and due to the cause(s)
To the within 2 within 2 to the comple	Med	29b. Signature and title of certifier	29c. License number	1	29d. Date signed (Month, Day, Year)
			05232	3	06-08-2007
02 H-2		30. Name and address of person who completed cause of death (Item 23a) (Type Khalid M. Wascem, 1126 Opal	Ct., Hagerstow	n, MD	21740
Sta Regist	ate rar	31. Date filed (Month, Day, Year)  JUN 1 1 2007  32. Figistrar's Signatule	Print) Ct., Hagerstow	,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 6/2/2007 **Physician** 9:40 am Joyce Klomparens Earman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 🔽 F 5/14/1925<sup>ar)</sup> Massachusetts 579-26-6432 82 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3727 Parke Dr. 21037 USA items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or itee 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Saltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: þ 3 Widowed 4 □ Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vera Elizabeth Webb Roy Klomparens ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sandra Wallace Daughter 318 Highland Dr. Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mayo U.M. Church Cem 6/7/2007 Mayo, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Liegnee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last This to the as a consequence of Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical use as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 4□Pregnant at time of death 5 ☐ Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1∐ Yes 217110 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2000 1 ☐ Yes 2 1 npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural 2 Accident (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

State Registrar

Medical

Dr. Eric Marcalus,MD

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AAMC Hospital Parkway Annapolis, MD 21401

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year) JUN 0 6 2007

3 ☐ Suicide

4 ☐ Homicide

(Check only

29b Signature and title of pertific

15 Certrying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D58166

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

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						Certificate of		Reg. I	46- UU /	20120
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	Funeral Director		5. Social Security Number 6. S 212-40-8801	Gex ′ 7.Ag I⊠M 2□F	e (lp/yrs. last birti 65	hday) tf Under 1 Year Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Yea Ir. 12,19	9. Birth Con 942 Mar	nplace (State or Foreign untry) yland
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	death with the Maryland me 23s or 28s-f show f must be notified at	5		•						10d. tnside City Limits 1 ☐ Yes 2 🕅 No
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8	ter death itame 2	era	11. Marital Status	12. Was Decedent	Ever in U.S.		Hispanic Origin? (Specifican, Mexican, Puerto Ric	Yes or No-	14. Race - Amer	ican Indian,
920	72 hours after death w natural', or iteme 23a	۾	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	Armed Forces? 1 XYes 2 □ N If Yes, Give Year or Dates:	√ 1960 <b>–</b> 1964	If Yes, specify Cubin	an, Mexican, Puerto Rid Specify:	an, etc.)	Black, White	.etc. ite
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b	를 찾을 받	BeC	17. Father's Name (First, Middle, Last	)			18. Mother's Name (F			
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ary	s 1 and 2 should be if Health and Mental I item 27 is marked or other treumatic eve		19a. Informant's Name/Relationship (	Type, Print)	19b.	Mailing Address (Street	and Number or Rural R	oute Number, City	y or Town, State, Zi	ip Code)
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ore	ges 1 av it of Hea if Item or othe		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □	Removal from State	20b. Place of cemetery	Disposition (Name of r, crematory or other place	Date	20c.	Location - City or T	own, State
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Baltimore,	permit. Pages Department of It Important: If Ite eny injury or of		21. Si a atur of Funeral Service Lice	* \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	1/2.	Zeller Fund	eral Home, arket, MD 2	P. O. Bo	x 207	
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Division	nding ath. r: Aft	afe	1		(Year) In		k? Yes 2 □ No			
vis	Attending death ector: Aby the fi	=======================================	3 ☐ Suicide 6 ☐ Could not be determined	9 28e. Ptace of this		n, street, factory, office	28f.	Location (Street :	and Number or Rur	al Route Number,
Ö	tal or	Cert		building, etc	. (Specify)			City or Town, Sta	110)	
	To the Hospital or Attending Physicien: within 24 hours ster death.  To the Funerel Director: After this certific cimpletely filled in by the funeral director,	edical Certification;	29a. Certifier 1 Utyling Ph (Check only 2 Medical Examone)	ynician: To the best on niner: On the basis of and manner sta	examination and	death occurred at the time for investigation, in my o	ne, date and place, and pinion, death occurred a	due to the cause it the time, date a	(s) and manner as and place, and due to	stated. to the cause(s)
	o thin	Me	29b. Signature and title of certifier			29c. Licens	e number	29d. D	ate signed (Month,	Day, Year)
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			30. Name and address of person who	completed cause of de	eath (Item 23a) (T	ype, Print)	1000 1000		PINT	
			G D C	3 Ce.	unic	to a Dife	The Co	3388t	teet	2012
77	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 200<sup>Year</sup> Helen Pearl Elliott June 16 7:00 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 725 Bladen Street Cecil Charlestown 5. Social Security Number 8. Date of Birth (Month Day, Year) 4/4/1931 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Davs 1 □ M 280 F Months Hours 219-28-7270 76 Director West Virginia Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28e-1 show the Medical Examiner must be notified at Director MD Cecil 1 Yes 2 No Charlestown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 725 Bladen Street 21914 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 No f Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: à Specify: 3 ₩Widowed 4 Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed what and Mental Hygier Is marked other th Homemaker 11 In Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Importent: If Item 27 1s marked any injury or other treumatic evonce. Arlie Franklin Sines Lillie Strader 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlestown, MD Anna M. Elliott (Daughter) 725 Bladen St. 21914 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mausoleum Harford Mem. Gdns. 6/20/07 Aberdeen, Maryland 22. Name and Address of Facility
Tarring-Cargo Funeral Home 21. Signature of Funeral Service/Licens Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE RESPIRATORY FAILURE Physician 2 DAYS /Medical Due to (or as a consequence of) Examiner ADENO CALLINGA LUNL Y 72701 Sequentially list conditions, in any, loading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Data to (or as a consequence of) Examiner be executed sician and burial-trans Box 687606 Due to (or as a consequence of) attending physician for use as the buria Physician/Medical The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by ONSTRUCTION 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Sec autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No Division of Vital 1 Yes To the Hospitel or Attending Physicien: director, Be 25. Was case referred to medical 26. Place of Death Check on one examiner Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending death. 1 ☐ Yes 2 ☐ No after death Director: / 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 4 Homicide 24 hours af Funerel D letely filled ii 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 133088 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 40 NUANSION SEWS BERGIN 1321 32. Registrar's Siggature Ygar) State Registrar

Demonte Donell Fowlkes, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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2	215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "naturial", or ttems 23a or 28a-f sho ent, the Medical Examiner must be notified at once.	ă l	10e. Street and Number					10f. Zip (	Code			. 52	10g. Ci	itizen of What		?
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	21215-0036 und be filed within 72 hours after Mental Hygiene. marked other than "natural", or revent, the Medical Examiner:	Be C		Done11	Fov	vlkes				Shee	na	Sl	nana	ae-		oals
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	5876 ertificate fing phy	an/N	23b. Was decedent pregnant in past 12 months?	the 1	Live birth Pregnant at ti		2			Ectopio	c pregna	ancy		Month	D	ay Year
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	Division of Vital Records, P.O. Box 68 tall or attending Physician: The law requires that the death certif as after death "an Director: After this certificate has been signed by the attending lied in by the funeral director, page 2 should be detached for use as		Part II. Other significant con	ditions contri	outing to death	but not res	sulting in the	underlying	g cause	given in Pa	art I.					he cause of death? ably 4 Unknown
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	of V g Phy: fter thi neral d	2 2	1 ✓ Yes 2 No 27. Manner of Death	28	a. Date of Injur	v T	28b. Time o		_	ıry at Wor	-	28d. Descr	ibe hov	v injury occurre	ed	
	ion tendin cath tor: A	atio			5/4/2007		Fnd 6:			Yes 2 X		unk	(Chan	et and Numbe	or or Bu	ral Route Number, City
	ivision At after d Direct d in by	Certification:	3 Suicide 6 X C	ould not be 2	8e. Place of Inju							or Toy	n. Stat	e)		Columbia, MD
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	a Cer	4 Homicide	Di dian T	Specify) four of the best of my	knowlode	no death oc	curred at th	e time	late and n	lace, an	d due to the	cause(s	and manner	as state	ed.
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4			30. Name and address of per	- 0	1		23a)									
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George Robert Farrell

seorge Robert		State of Maryland / Department of Health and Mental  1. For State  Certificate of Death  Registrar		eg. No. 2 ft i	7 2012
Physici	an/	Decedent's Name (First, Middle,Last)	2. Date of Deat Month June 10, 2		3. Time of Death 2159 hrs
Medical Exami	ner	George Robert Farre11  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of De		4c. County of Deat	
		27168 Mechanicsville Rd. Mechanicsville		St. Mary's	
Funeral Director		219-04-6243 1X M 2 F 33 Yrs. Months Days Hours I	Hrs. 8. Date of Bir Min. July 8	th(MM/DD/YYYY) 9. Bi Forei Co	rthplace (State or gn Maryland ountry)
d how any ee.		Usual Residence of Decedent  10a. State			10d. Inside City Limits  1 Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 10f. Zip Code 27168 Mechanicsville Road 20659	11	0g. Citizen of What Cou USA	Intry?
death with or items 23 must be no	Funeral	11. Marital Status 1 Never Married 2 X Married    12. Was Decedent Ever in U.S.   Armed Forces?   1 Yes 2 X No    13. Was Decedent of Hispanic Origin?   If Yes, specify Cuban, Mexican, Put		White, etc.	rican Indian, Black,
s after rral", o	5	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind	of work done	Specify: 16b. Kind of Business	White
2 hour "natu	eted	Elementary/Secondary (0-12) College (1-4 or 5+)		Teb. Killd of Busilless	rindustry
036 /ithin 7 ene. er than	Completed	8 Concrete Laborer		Construc	ction
21215-0036 suld be filed within 7 Mental Hygiene. marked other than c event, the Medica		Touton	ame (First, Middle, Mi	_ ′	_
212 212 uld be Menta marke c even	To Be	George Archie Farrell  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number			e, Zip Code)
MD nd 2 sho alth and m 27 is		Mishelle Lea Farrell / Wife 27168 Mechanicsville Roa		csville, MD 2	
Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tra		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition (Name of cemetery, crematory or other place)  Charles Memorial Gardens	Date June 15, 2007	20c. Location - City o	
Salti ermit. Separtn mport		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner	Funeral Ho	ome, P.A.	
Physician	-	23a. Part I. Enter the disea or commit c tions that caused the diath. Do not enter the mode of dying, such as cardia	nardtown, MI	20650	Approximate Interval
/Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):			Between Onset and Death
		Sequentially list conditions, b			
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last used to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):			
ecuted and transit		d.			
60, ate be ex obysician	Medical	UNPENDED			
\$876 rtiffcate ing phy as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pre	egnancy	23d. Date of delive Month	ry Day Year
Box 687 certificate death certificate attending produced as the	Physician/	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown 9 Unknown			
2 . 2	à	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute to	
cords, P law requires t has been sign e 2 should be c	Completed			psy prior to rmed? death?	utopsy findings available completion of cause of
tal Rection: The certificate		25. Was case referred to medical 26.Place of Death (Che	1 Yes	2 No 1 V	es 2 No
Vita tysicia this cer direct	To Be	eyaminer?		Residence 6 🗸 Othe	er: Scene
Division of Vital Records, P.O. ours after death. The law requires that the ours after death.  The law requires that the our After this certificate has been signed by filled in by the funeral director, page 2 should be detact		27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month Day Year)  Jun 10, 2007  28b. Time of Injury 28c. Injury at Work?  1 Yes 2 ✔ No	28d. Describe Subject sho	how injury occurred t self	
Divisi popital or Ati hours after d meral Direct	Certification:	2	or Town, S		tural Route Number, City anicsville, MD
To the Hospita within 24 hours To the Funeral completely fille	Medical C	29a. Certifier (Check only one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated.			
F*F8	Me	29b. Signature and title of certifier  29c. License number O.C.M.E.		29d. Date signed <i>(M</i> June 11, 2007	onth, Day,Year)
01		30. Name and address of person who completed cause of death (Item 23a)	NAD 04004		
	ate	Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, 31. Date filed (Month, Day, Year) 32. Religistrar's Signature.	IVID 27207		
Regis	trar	31. Date filed (Month, Day Year) 2 2007 32. Relistrar's Signature			

DHMH 17 Rev 1/2001 OCME 2006

216-40-6531   Image: Secondary Common   Im				1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	ertificate of			iene () () /	20130
Frances Yvonne  Examiner  # Frances  #		Physici	an	1. Decedent's Name (First, Middle							3. Time of Death
Purce of Directors   Scient Section Neurons   Carlot Section   Scient Section Neurons   Carlot Section   C	v:			Frances	Yvonne	Gas	S				10:31a <sup>M</sup>
Second Security Number   Second Security Number   Security Numbe		Examin	er							4c. County of Death	1
216-40-6531   Image: American Control	Н					o /lours lost high do			O Date of Dist		
The part of the	ŀ		,	216-40-6531		Ven			(Month, Day,	Year) Coi	nplace (State or Foreign untry) corgia
Process of the proc		land ow				10c. City, Town or I	_ocation				10d. Inside City Limits
Process of the proc		Man	to	Maryland St.	Mary 'e	Mechan	icevilla				1 ☐ Yes 2€No
Process of the proc		or 28g	lrec		inity b	псснаг			10	g. Citizen of What Co	untry?
Process of the proc		23a (		27374 Birch M	anor Circle		206	559		USA	
Physician   Medical   September   All   Septem		terne	une		Armed Forces?	Ever in U.S. 13	. Was Decedent of I	Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No- Rican, etc.)		
Physician   Medical   September   All   Septem	20	s afte	Ž.		If Yes, Give	No					hite
Physician   Medical   September   All   Septem	3	hour	edt			16a Dec	edent's Usual Occur	nation		I6h Kind of Business/I	ndustry
Physician   Medical   September   All   Septem		n ne n ne	plet	(Specify only higher	st grade completed)	(Giv	e kind of work done	during most of work	ing	OD. Kille of Besilless	noostry
Physician   Medical   September   All   Septem	7	d with	mo		College (1-4or 5	,	inistrati	ive Secret	ary	SMECO	
Physician   Medical   September   All   Septem	2	al Hy al Hy fother	a	17. Father's Name (First, Middle,				18. Mother's Name	e (First, Middle, M	faiden Sumame)	
Physician   Medical   September   All   Septem	ya	Ment Ankec arkec	10	Carl Rhub	en Fulle:	r		Thelma	C.	McC1ur	e
Physician   Medical   September   All   Septem	Jar	2 sho									
Physician   Medical   September   All   Septem	ຮ້	1 and 10aith 1m 27 ther t	}		lliams/Daugh						
Physician / Medical Examiner  Sequentially list conditions, and up to (or as a consequence of):  Due to (or		f ite		1 ■ Burial 2 Cremation		cem <i>etery</i> , cri	ematory or other pla	ice)	-		
Physician / Medical Examiner  Sequentially list conditions, and up to (or as a consequence of):  Due to (or		it. Partitude in transfer in jury									
Physician / Medical Examiner  Sequentially list conditions, and up to (or as a consequence of):  Due to (or	Ö	Depa Impo		Jan 11	ACT	0641	Brinsfie	ld-Echols	Funeral	Home, P.A.	i1 MD 20623
The second of th	)	/Medical		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on each lin	static	nter the mode of dyi		•	st.	Approximate Interval Between Onset and Death 2 Years
25. Was case referred to medical examiner?  1	,00/00	ficate be executed physician and s the burial-transit	dlcal	that initiated events	Due to (or as						
25. Was case referred to medical examiner?  1	.O. BOX	the death certii y the attending ached for use a	nysician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetel death 3		y			very Day Year
25. Was case referred to medical examiner?  1	ν̂ L	ss that gned b		Part II. Other significant condition	ens contributing to death bu	ut not resulting in the	underlying cause giv	ven in Part I.	23e. Did tob	acco use contribute to	the cause of death?
25. Was case referred to medical examiner?  1	5	equire en si ould t							1 🗆 Ye	s 2 □ No 3 (2) or o	bably 4 □Unknown
26. Place of Death (Check only one)  27. Manner of Death   Specify   Check only one	בים ול	: The law r cate has be ; page 2 sh	Comple						autopsy	prior to c death?	topsy findings available completion of cause of 2 No
The state of the s	Ĭ	ician certifi rector	00	examiner?	Hospital:		Ott			<del></del>	Sister's
3 Suicide 4 Homicide 3 Suicide 4 Homicide 3 Suicide 4 Homicide 4 Homicide 4 Homicide 5 Suicide 4 Homicide 5 Suicide 6 Suicide		ending Physiath. or: After this ne funeral di		27. Manner of Death  Natural 5 Pendin 2 Accident investig	28a. Date of Injur (Month, Day	ry 28b. Time	of 28c. Injur	ry at rk?			<sup>#</sup> /Residence
29a. Certifler (Check only one)  29a. Certifler (Check only one)  29a. Certifler (Check only one)  29b. Signature and title of certifier  30. Name and address oberson who completed cause of death (Item 23a) (Type, Print)  37767 MARKET DIR. Charlet He time, date and place, and due to the cause(s) and manner as stated.  29a. Certifler (Check only one)  29a. Certifler (Check only one)  29a. Certifler (Check only one)  29b. Signature and title of certifler  29c. License number  29d. Date signed (Month, Charlet one)  30. Name and address oberson who completed cause of death (Item 23a) (Type, Print)  37767 MARKET DIR. Charlet one)  37767 MARKET DIR. Charlet one)		s after de	Certific	deter	ined   286. Place of Inju	ury - At home, farm, s c. (Specify)	treet, factory, office				ral Route Number,
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, L. Charlette All MD 20622  29d. Date signed (Month, L. Charlette All MD 20622  MARY		he Hospi in 24 hour he Funer pletely fill		(Check only 2 Medical	examiner: On the basis of	examination and/or i	th occurred at the ti nvestigation, in my o	me, date and place, opinion, death occurr	and due to the cared at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 37767 MARKET DIR. Charlette Hall MD 20622 MARY	,	5 # 5 P				MD	29c. Licens	se number	2 29	d. Date signed (Month	2007
and the state of t		0,"		30. Name and address of person	who completed cause of de	eath (Item 23a) (Type	Print) He Ha	Il MD a	20622	MARY	/ KAMER

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Registrar

10

State Registrar

DHMH 17 Rev 1/2001

PLEASANT VALLEY BLVD. ALTOGMA, PA 16002-4377

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

OR KATARI

JUN 2 1

31. Date filed (Month, Day, Year)

			1 _ State	aryland / Depa <i>Cer</i>	artment of F ctificate of t		lental Hygie Reg	-/1111/	20132
	, K	8	Registrar  1. Decedent's Name (First, Middle, Last)	007	timodito or i	J Gair.	2. Date of Death	. 140.	3. Time of Death
	Physici		Vicki Diane Hall				June 1	Day Year	09:39 AM
ì	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	r Location of Death		4c. County of Death	
			Julia Manor Health Care		Hage	erstown		Washingto	on County
	Funeral		5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year Months Days	erstown   If Under 24 Hrs.   Hours   Min.	8. Date of Birth (Month, Day, Y	9. Birth	place (State or Foreign ntry)
24	Director		244-56-8148	67 Yrs.			March 31		h Carolina
and	*		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation			T	10d. Inside City Limits
Maryl	f sho led at	ō	Maryland Washington		Hage:	rstown			1 <b>y</b> Yes 2 □ No
the	28a-	Director	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Cou	ntry?
5-0035 72 hours after death with the Maryland	ntal Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	al D	333 Mill Street		2	1740		U	S.A.
deat	ems 2	Funeral	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S. 13. V	Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri Black, White	
after	or Ite	F.	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes Give	No	1 □ Yes 2 🛣 No	Specify:	Thousand order	Specify: Wh:	
5-UU3b 72 hours af	ural",	d by	3 Widowed 4 Divorced Year or Dates:	16a Danas	dent's Usual Occup	ation	10	b. Kind of Business/li	advote.
72 n	"nat edice	lete	15. Decedent's Education (Specify only highest grade completed)	(Give	kind of work done	during most of work d)	ing	b. Kind of Business/fi	idustry
d Z1Z1	iene. thar	Completed	Elementary/Secondary (0-12) College (1-4or 5	5+)	Film Sp.	licer		Photograpl	n Company
_ ~	other ent,	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Ma	iden Surname)	
yland ould be file	fenta rked tlc ev	To B	Clifford Smith			Gladys	Yount		
Mary d 2 shoi	and Mental is marked or raumatic eve		19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	ng Address (Street	and Number or Run	al Route Number, C	city or Town, State, Zi	p Code)
and 2	n 27 i		David R. Hall -Son					oro Maryla	
<b>Saitimore,</b> permit. Pages 1 a	t of H If item or oth		20a. Method of Disposition  1X Burial 2 □ Cremation 3 □ Removal from State		matory or other plac	ce)		c. Location - City or T	
ti Pa	tmen tant: njury		4 □ Donation 5 □ Other (Specify)		en Cemet	-		agerstown	
permi	Department of Health and Menta Important; If item 27 is marked any injury or other traumatic evonce.		21. St nature of Funeral Service Licensee				_	Fiery Fund stown Mary	ral Home land 21742
10			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each li						Approximate Interval Between
Ph	ysician			erebral		farct			Onset and Death
<i>)</i> //	Medical		resulting in death)	a consequence of):		1227			
E	caminer	١. ا	Sequentially list conditions.	hronic	Rin	al )	sease		
pe	sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence ofy	abot	in tu	Lyne	Dicease	
xecut	and I-tran	Examin	triat irilliated events	a consequence of):	0 93 (	VV/ C1, VX		101240	
cate be executed	physician and the burial-transit	dical E	A	trial	F; b	vi hat 10	4	Disease	
	g phy:	edic	0.						
death certifi	ending use a	In/M	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant		Tectonic prognance			23d. Date of deliv	very
deatl	been signed by the attending should be detached for use as	Physician/Me	1 Yes 2 No 4 Pregnant a		∃Ectopic pregnance ☐ Other (specify) _	у		Month	Day Year
a ta	by th	hys	9 Li Unknown				9		
ords, P	igned be de	by	Part II. Other significant conditions contributing to death b	out not resulting in the ui	nderlying cause giv	en in Part I.		oco use contribute to	
ord requir	een s ould	ted						2 No 3 Pro	ibably 4 Delikilowii
Hecord he law require	as b e 2 st	Completed					24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
	certificate has t irector, page 2 s	ပ်						d2 death? No 1 ☐ Yes	2 No
Or VITAI Physiclan: T	certifi	Be	25. Was case referred to medical examiner?		oth	or:	h (Check only one)		
P &	ı. After this funeral dii	<u>۲</u>	1 Yes 2 No nospital 1 Impati 27, Manner of Death 28a. Date of Inju		IL 3 DOA	4 Li Nursing Ho	me 5 Residence 28d. Describe how	ce 6 □Other (Speciniury occurred	ify)
VISION	h. : Afte : fune	tion	1 ☑ Natural 5 ☐ Pending (Month, De 2 ☐ Accident investigation	y Year) Injury	f 28c. Injur Wor M 1 □	rk?  Yes 2 □ No		,	
UIVISION I or Attending	after death.  Director: A in by the fi	ifica	3 Suicide 6 Could not be 28e. Place of inj	jury - At home, farm, str tc. (Specify)	eet, factory, office		28f. Location (Stree City or Town,	et and Number or Ru	ral Route Number,
5 è	s afte	Certification:	4 Tromicide Building, e	ic. (Opecny)			Only or rown,	Siale)	
ie Hospif	within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical (	29a. Certifier 1 Certifying Physician: To the best (Check only one) 4 Medical Examiner: On the basis of and manner st	of examination and/or in					
To th	withii To the	Me	29b. Signature and title of certifier		29c. Licens		<i>i</i>	Date signed (Month	, Day, Year)
•			Jum	denth (litery DO: ) (T		160391		1	
BH	-2		30. Name and address of person who completed cause of c	- SAED	110	-6 Op	ctown c	mp 2	1740
18 og		ate	31. Date filed (Month, Day, Year) 32. Regist	rar's Signature	1		,		
	Regist	rar	JUN 1 2 2007 June	un D. By	neke				

State of Maryland / Department of Health and Mental Hygiene. U U / For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death . 2<u>007</u> **Physician** June 10, 2150 Robert Jay Hancy /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Havre de Grace Harford Memorial Hospital Harford If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 3 M 2 □ F New York 89 Yrs. 104-18-7966 Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a State 10b. County or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21001 U.S.A. 618 Colaine Drive Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No WWII If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married ŏ If Yes, Give Year or Dates: Korea 1 ☐ Yes 2 X No Specify: Specify: White 3€XWidowed 4 □ Divorced "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) le marked other then College (1-4or 5+) Elementary/Secondary (0-12) 12 U.S. Air Force Military 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: if Item 27 is marked oth eny injury or other traumatic event 90cg. Be Caroline Covert Jay Hancy 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jackson, NJ 5 Inverness Ln. Dennis W. Hancy (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 6/14/07 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Mem. Gdns. 21. Signature of Funeral Service 22. Name and Address of Facility Funeral Home, P.A. 23a. Part1. Enter the disease, or completions that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Aberdeen, Maryland 21001-3399 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a. luit disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 4 F Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner Myoral use as the burial-transit nid.ac Due to (or as a consequence of): The law requires that the death certificate be DD Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant sate has been signed by the atter page 2 should be detached for u 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4□ Pregnant at time of death 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ۾ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No certificate or Attending Physicien: After this certification, funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 / Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manney of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 10062903 06/11/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) De Grace, MD 21078 ATRASH, MD Havie 319 Ave Un.on

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 1 2 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Vear George Washington Hale June 08, 2007 8:48 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 46528 Valley Court, Apt.# 3007 St. Mary's Lexington Park 1 Year If Under 24 Hrs.
Days House Social Security Number 7. Age (In yrs. last birthday If Under 1 **Funeral**  Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Director 428-42-1621 04/22/1928 Mississippi Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. inside City Limits Director 1 ☐ Yes 2X No Maryland St. Mary's California 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be 21483 Dana Court Funeral 20619 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 1 ∑ Yes 2 □ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 □ No Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Completed by 3 Widowed 4 Divorced Specify: White "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Civil Service other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill thent of Health and Mental H tant: If them 27 is marked oth Jury or other traumatic even Be 2 George Washington Hale <u>Loraine Blankinship</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ant of He. Arant: If Item 2> Dorothy Hale/ Wife 570 Bellerive Road, Apt. 406, Annapolis, MD 21404 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) aryland Veterans Cem 06/14/2007 Cheltenham, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 22955 Hollywood Road, Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such es cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Closease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): il or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and in by the funetal director, page 2 should be detached for use as the burnarithmist Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 4☐Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Division or Vital Records, P.O. 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 200No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Daughter's Home 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) Injury 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral D Zertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number H 0055751 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) n who completed cause of death (Item 23a) (Type, Print) 30. Name and address of D.O., 4U) Jennifer/Schmidt, 40900 Merchants Lane, Suite 205, Leonardtown, Maryland 20650

Registrar

State

31. Date filed (Month, Day, Year)

JUN 1 2 200?

Division or Vital Records, P.O. Box 68760, 

> State Registrar

Medical

29a. Certifier

(Check only one)

31. Date filed (Mon

29b. Signature and title of certifier

Shaveri-

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

0032651

Rita B. Jhaveri, M.D.

29d. Date signed (Month, Day, Year)

10-01			1- State of Maryland / Dep State of Maryland / Ce	artment of Health and N rtificate of Death	Reg. N	2001 20130
1	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death  Month	3. Time of Death
	Physici /Medic		Kate Emma Harris		June 12	2007 7:30 A M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death
			45392 Capps Court	California		St. Mary's
E.S.	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
No. 144	Director		217-72-7973 1□ M 2X F 70 Yrs.		06/07/193	
	pr ,		Usual Residence of Decedent  10a State 10b County 10c City, Town or L	nontion .		10d. Inside City Limits
	irylar show	_	10a. State 10b. County 10c. City, Town or L	ocation		1 ☐ Yes 2X No
	e Ma ka-f s	5	Maryland St. Mary's Hollywood	1		
	th th	Director	10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Country?
	th wi	<u>=</u>	42590 St. John's Church Road	20636	Uı	nited States
	dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.
9	after or ite nine		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give	1 ☐ Yes 2 X No Specify:	, , , , , , , , , , , , , , , , , , , ,	
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21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ding 16b.	Kind of Business/Industry
	within lene. than " he Med	합	Elementary/Secondary (0-12) College (1-4or 5+)			
	filed within Hygiene. ther than "	So	12	emaker		vn Home
Maryland	0 = 0 %	Be	17. Father's Name ( <i>First, Middle, Last)</i>	18. Mother's Nam	e (First, Middle, Maid	en Surname)
<u>la</u>	should by the Menta marked umatic ev	ပ	Henson Lyon		Louise Higg	
a	C C S		19a. Informant's Name/Relationship (Type. Print)	ing Address (Street and Number or Ru	ral Route Number, Cit	y or Town, State, Zip Code)
	Health tem 27 l			2 Capps Court, Cal		
Baltimore,	item		20a. Method of Disposition 20b. Place of Disposerity, cre	osition (Name of ematory or other place)	Date 20c.	Location - City or Town, State
Ĕ	permit. Pages 1 Department of h Important: If ite any injury or ot		1 Nation State 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) St. John	's Cemetery 06/1	5/2007 Ho	llywood, Maryland
alti	permit. Pag Department Important: I any Injury o once.			2. Name and Address of Facility Bri	nsfield Fu	ineral Home. P.A.
ñ	Deg any one		Edward N. Bransfield, Jr. M00052 2			
- OL			23a, Part1, Enter the disease, or complications that caused the death. Do not en			Approximate Interval Between
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	Physician /Medical		disease or condition resulting in death) a.  Due to (or as a consequence of):	Renal (el	(ava	NOME JAN
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387	icate phys	dical	0.			
×	leath certific attending p	Physician/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of delivery
Вох	atter for u	iar	In the past 12 morals?	☐Ectopic pregnancy ☐ Other (specify)		Month Day Year
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ec	law lasb	age .			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
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/ita	Physician: r this certifica ral director, p	Be (	25. Was case referred to medical examiner?		th (Check only one)	
7	≥ .20 0	은	1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient			6 Mother (Specify) Daughter's
n 0	ding Pl		27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day Year) Injury Injury		28d. Describe how in	njury occurred
0	ath. or: A	atic	2 ☐ Accident investigation	M 1 ☐ Yes 2 ☐ No		
<u> </u>	r Atte	Ę	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, late)
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier (Check only (Ch	ath occurred at the time, date and place investigation, in my opinion, death occu	, and due to the cause	e(s) and manner as stated. and place, and due to the cause(s)
	he H in 24 he Fi plete	Medical	one) and manner stated.			
	To t To t	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type 24035 Three NotCh fel	1) 36206	6	112107
			30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)		
				H0117W000	MD 2	2636
		ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Regist	rar	JAN 1 8-2007 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			

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68760,	tificate be executed	g physician and as the burial-transit

		For State Registrar	State of Mary	•	artment of F <i>rtificate of</i>		Mental Hy		000"	
		Registrar  1. Decedent's Name (First, Middle, La	st)	Ce	runcate of	Deam	2. Date of D	Reg. No.	200	3. Time of Death
Physici		Phyllis Ann	Hopewell				Month June	Day	Year 2007	M
/Medi Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Dea			County of Deal	8:56 p <sup>™</sup>
		Civista Medica	al Center		La P1				Charle	es
Funeral		Social Security Number 6. 8	□M 2NF	yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	n. (Month, D	ay, Year)	9. Birt	hplace (State or Foreign ountry)
Director		220-38-2578 Usual Residence of Decedent	6	66			01/29	/1941	Mar	yland
/land ow		10a. State 10b. County	100	c. City, Town or Le	ocation					10d. Inside City Limits
a-f sh	ģ	Maryland St. Mar	v <sup>†</sup> s M	echanics	villa					1 ☐ Yes 2 💢 No
or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citi:	zen of What Co	ountry?
ath wi		26198 Three Note			20659			Unit	ed Sta	tes
er de	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? ( an, Mexican, Pue	Specify Yes or Nerto Rican, etc.)	0-	<ol> <li>Race - Ame Black, White</li> </ol>	
is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It has the marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by F	1 Never Married 2 Married 3 XWidowed 4 Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		1 ☐ Yes 21X No	Specify:			Specify:	lack
2 hou atura	ted	15. Decedent's E	ducation	16a. Dece	dent's Usual Occu	pation		16b. Kir	nd of Business/	
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be fill Hall Hall He even	æ	17. Father's Name (First, Middle, Last	)			18. Mother's Na	ame (First, Middle	e, Maiden	Surname)	
12 should be filed within h and Mental Hygiene. Is marked other than traumatic event, the Me	은	Joseph H. Jordan  19a. Informant's Name/Relationship		10h Maili	ng Address (Street	Mary E.		h 0't	- T 04-4- 1	7.0.43
and 2 sleath an n 27 ls r									, ,	' /
s 1 and 2 f Health tem 27 other tra		Monica R. Barnes		<ol><li>Ob. Place of Disp</li></ol>	2 Athlone of Name of	1	Great M	20c. Lo	MD 2( cation - City or	)634 Town, State
Pages 1 and the ment of He mut: If item		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		-	matory or other pla Peace Co	i	16/2007	Uala	- Mass	-1 3
a + 5 2 5 5		21. Signature of Funeral Service Lice			2. Name and Addre	ess of Facility B	cinsfiel	d Fun	eral Ho	ome. P.A.
permi Depar Impo		Edward N. Brins	field Jr. M		2955_Holl					
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	death. Do not en	ter the mode of dyi	ng, such as cardi	ac or respiratory	arrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	a. Anaphyl	lactic	Reactio	n				Onset and Death
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	<u>.</u>	Sequentially list conditions,	b. Oral ra		ic cont	rast				6 hours
rted	i i	Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury								and 50 minutes
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ficate be executed floated and physician and is the burial-transit	edical		_d							
	Med	IF FEMALE:								· — —
death certiff attending for use as	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pr 1 Live birth 2	Fetal death 3	⊒Ectopic pregnanc	у		2	3d. Date of del Month	ivery Day Year
the de	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	of death 5	Other (specify) _				mortan	Day
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The law te has I	Completed			·			per	opsy formed? 2 No	prior to death? 1 ☐ Yes	completion of cause of
	Be C	25. Was case referred to medical examiner?				26. Place of De	1 Yes eath (Check only		I I I I es	20110
hysic his ce	To E	1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	nt 3□ DOA Oth	ner: 4 ☐ Nursing	Home 5 ☐ Res	sidence 6	G □Other (Spe	cify)
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teath.	cati	2 Accident investigation 3 Suicide 6 Could not b	9	At home from at		Yes 2 □ No	201 1 11	· · · ·		
or A after o	Certification:	4 ☐ Homicide determined	28e. Place of injury - building, etc. (S	pecify)	reet, factory, office		City or To	(Street and own, State)	d Number or Ru	ural Route Number,
To the Hospital or Attending Physician; within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director,		29a. Certifier 1 CertifyIng Pl	ysician: To the best of my	/ knowledge, deal	h occurred at the ti	me, date and pla	ce, and due to the	e cause(s)	and manner as	s stated.
e Ho	Medical	(Check only 2 ☐ Medical Examone)	niner: On the basis of exa and manner stated.	mination and/or ir	vestigation, in my	opinion, death oo	curred at the time	e, date and	place, and due	to the cause(s)
To the To the To the Comp	Me	29b. Signature and title of certifier	2		29c. Licens	se number		29d. Date	e signed (Mont	h, Day, Year)
		•	ruelle	<u>u</u>	DO	046952		6	110/7	L-
		30. Name and address of person who	•		,				1-1-/-	
		Sukhjit Sidhu, 31. Date filed (Month, Day, Year)	1000 Parl	Forty	Plaza	Suite 1	10 Dur	ham	NC 277	713
Sta Registi		JUN 1 3 2087	32. Registrars	Sandy .						
DHMH 17 Rev 1/2	-		4	1000						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2

		1	For State Registrar	State of Maryla	•	rtificate of De			leg. No. 2 0 0	7 201	33
			Negistrar     Necedent's Name (First, Middle, Las	t)				2. Date of Dea Month		3. Time of De	ath
	Physicia		Dorothy Mae Ha	ıvden				May	30, 200		M
	/Medica		4a. Facility Name (If not institution, give			4b. City, Town, or Lo		,	4c. County of	Death	
	100		University Specia	lty Hospital		Baltimore					
	Funeral		Social Security Number     6. S	ex 7. Age (In yı	rs. last birthday)		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	r, Year)	. Birthplace (State or F Country)	oreign
	Director		216-40-8922	64	Yrs.			June 1	7,1942	Maryland	
7	3	-	Usual Residence of Decedent  10a, State 10b, County	10c.	City, Town or Lo	ocation				10d. Inside City I	_imits
A) a C	sho	5	MD Charle	es	La Plat	ta				1 ☐ Yes 2	No K
4	28a-f	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?	
4	t be r		5790 Bowieland H	21200		206	46		USA		
1	ns 23	Funeral	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,		ecify Yes or No-		American Indian, White, etc.	
	r iter		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No			Specify:	riican, etc./	Specify:		
3	ral", o	ğ	Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		Λ				white	
	natul lical	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Dece (Give	dent's Usual Occupati kind of work done du DO NOT use retired)	ion ring most of work	ing	16b. Kind of Busi	ness/Industry	
V	Mec.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)					Restaura	ant	
١ -	ygier ygier it, the	S	11		Wait	ress/Night			Maiden Surname)		
2 .	tal H	Be	17. Father's Name (First, Middle, Last,			'	Lilly G		,		
y 10	z should be fined writin 72 hours after obsett with the invaryation, and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	유	Joseph Ignatius I		19h Maili	ing Address (Street an			er. City or Town. Si	tate. Zip Code)	_
	h and		19a. Informant's Name/Relationship (			Sydnors Mi					
້.	permit. Pages 1 and 2 should be filed within 72 hours after death with the way year to Health and Mental Hygiene. Inpoparment of Health and Mental Hygiene. Inpoparant: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Virginia Boarman, 20a. Method of Disposition	Sister		osition (Name of ematory or other place)		Date		ity or Town, State	
5	ages nt of : #it		1 ☐ Burial 2 【X Cremation 3 ☐	IRemoval from State		$1  ext{d-Echols}$ (	1	1/07	Charlot	te Hall,MD	
	rtme rtani njury		4 □ Donation 5 □ Other (Specification Specification Specification Service Licentary	100000		22. Name and Address AREHART—EC				Le naii, no	
0	Depail Impoil any Ir				1	AREHART-EC	HOLS FUN	ERAL HO	ME,P.A.	20646	
	1000	1	23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused the d	eath. Do not en	ter the mode of dying,	, such as cardiac	or respiratory a	rrest,	Approximate Interval Between	een -
	Neveleiee		Illinediate Cause (Final	Respirate	orv Fai	lure do to	COPD			Onset and De	ath
d <sub>i</sub>	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a con:		2010 00 00	0012				
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o o	ath ce tendi	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pre 1☐Live birth 2☐I	Fetal death 3	□Ectopic pregnancy			23d. Date Mon	of delivery th Day Y∈	ear
7.	e dea the at ted fo	Sici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	of death 5	Other (specify)					
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	ding I h. After funer	ion	1X Natural 5 ☐ Pending	(Month, Day Yea			? ′es 2 □ No				
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1810	# D O >		4 Homicide	building, etc. (Sp	респу)			City or 10	own, State)		
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DIVISIO	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical Cert	(Check only 2 Medical Example)  29b. Signature and title of certifier	aminer: On the basis of exa- and manner stated.	knowledge, deamination and/or	investigation, in my op	number	urred at the time	o, date and place, a 29d. Date signed	(Month, Day, Year)	
DIVISIO	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by		(Check only 2 Medical Example)  29b. Signature and title of certifier	aminer: On the basis of exa	knowledge, deamination and/or	investigation, in my op	number	urred at the time	e, date and place, a	(Month, Day, Year)	

State Registrar SEBLU ZERA - YOHAW NES 31. Date filed (Month, Day, Year) 32. Refs

JUN 0 8 2007

DHMH 17 Rev 1/2001

601 South Charles St, Baltimore, MD 21230

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 7:07 a.<sup>M</sup> Julia Triplett Henry June 2 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chesapeake Woods Center Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F **Director** 79 213-22-8122 Nov. 28, 1927 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits show item 27 is marked other than 'natural', or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16 Merryweather Drive 21613 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) secretary planning & zoning 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H ant: If Item 27 is marked ott Harvey E. Triplett Celeste Spedden 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other trains Ann Henry daughter 16 Merryweather Dr., Cambridge, MD 21613 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Mem. Park 6/6/07 Cambridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due to (or as a consequence of) Examiner static if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and bunal-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown tate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2□ No 1 ☐ Yes 1∐ Yes 20 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2**X**No 1 ☐ Yes 1 🔲 Inpatient P 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: al or Attending Fafter death. 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours aff To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bramble Street Cambridge, MD 21613 100 State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of M	Maryland / Depa Cei	artment of H rtificate of L			ene () ()	7	20140
	186.14		1. Decedent's Name (First, Middle	e, Last)				2. Date of Death Month	_	ear	3. Time of Death
	Physici /Medic		Daniel Andrew	Ha <b>l</b> 1				June		007	11:15 PM
	Examin		4a. Facility Name (If not institution	n, give street and number	ar)	4b. City, Town, or	Location of Death		4c. County of Death		
1		7. Jej	60 Love Run Ro	oad		Color	ra		Cec	i 1	
	Funeral*		5. Social Security Number		Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, )	(ear) 9	Birthpla	ace (State or Foreign
¥1	Director		219-14-2385	1 <b>∑</b> M 2□F	83 Yrs.	Morning Days	110013	Jan. 21,	1924	Mar	yland
	D .		Usual Residence of Decedent		100 City Town and					10	d. Inside City Limits
	aryta shov	_	10a. State 10b. County		10c. City, Town or Lo					10	1 ☐ Yes 212 No
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	ith th	Die	10e. Street and Number			10f. Zip Code		100	g. Citizen of Wh		ry?
	ath v	by Funeral Director	60 Love Run Re			2191			USA		
	er de	nue	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spi n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Black,	White, e	
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12	within ene. then "	E .	Elementary/Secondary (0-12)	College (1-4d	or 5+)	ation Spec			US Gov	70 <b>rn</b> :	ment
	Hygid Hygid other	ပို	17. Father's Name (First, Middle,		Buuca	cron spec	18. Mother's Name	First, Middle, Ma			merre
an	Mentai arked o	o Be	Miller A. Hal	1			Fugen	ia Hawke			
2	should nd Men marke	မ	19a. Informant's Name/Relations		19b. Mailie	ng Address (Street a			City or Town, St	ate. Zip	Code)
Maryland	id 2 sho th and 27 ie m		Richard E. Ha			Limerick 1					ŕ
<b>a</b>	s 1 and 2 should be filed within 72 hours after death with the Marylan I Heatih and Mental Hygener I Heatih and Mental Hygener I Heatih and Mental Hygener I Heatih St. in marked other then "naturel", or items 23s or 28e-f show other traumatic event. The Medical Examiner must be notified at		20a. Method of Disposition	11/ 5011	20b. Place of Dispo	sition (Name of			Oc. Location - Ci		wn, State
ᅙ	nt of nt of t: if if		1 X Burial 2 ☐ Cremation		10	natory or other plac		2007	0 - 1	14	(S)
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			23a. Part1. Enter the disease, or shock or heart failure. List	r complications that caus only one cause on each	sed the death. Po not ent in line.	er the mode of dying	g, such as cardiac	respiratory arres	st,	71	Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition	. Trre	State	Canc	en wi	th Si	oinal		Oriset and Death
	/Medical		resulting in death)	Die to (or	as a consequence of):			_ /			
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	p ii	ine	if any leading to immediate	Due to (or	as a consequence of):						
	tificate be executed g physician and as the burial-transit	Examiner	cause. Enter Underlying that initiated events resulting in death) Last	C. Dua to /or	20.0.0000000000000000000000000000000000						
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68760,	icate be execul physiclan and s the burial-tran	dical		d							
4	ertiflik ding p		IF FEMALE:	23c. If yes, outcor							
Вох	death certifi e attending id for use as	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death 3	Ectopic pregnancy			23d. Date of Month		ry Day Year
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<u>م</u> '	requires that the een signed by th nould be detache	F.	Part II. Dther significant conditi	ons contributing to death	h but not resulting in the u	nderlying cause give	en in Part I	23e. Did toba	acco use contrib	ute to the	e cause of death?
Records,	signe signe	l by		commoning to comm							ably 4 Munknown
0	w requir been si should	Completed									
Sec.	ed ou CA	ф						24a. Was an autopsy perform	pri		osy findings available inpletion of cause of
	Th ate pag	S						1□ Yes 2			2 1 No
of Vital	Physician: Th this certificate al director, pag	Be	25. Was case referred to medica examiner?	Hospital:		Oth		h Check only one	)		
of	this al di	P.	1 Yes 2 No	Hospital: 1 Inp			4 🗀 ivursing no	me 5 🖾 Resider			)
E C		lon	27. Manner of ath 1 Inural 5 Pendir		njury 28b. Time o Day Year) Injury	Worl		28d. Describe how	w injury occurred	1	
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Division	or All	Certification:	4 Homicide determ	nined 286. Place of building,	Injury - At home, farm, stretc. (Specify)	eet, factory, office		28f. Location (Stre City or Town,		or nura	Houle Number,
]	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the		29a. Certifier 1 0 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ng Physician: To the be	est of my knowledge, deat	h occurred at the time	ne, date and place	and due to the car	use(s) and man	ner as st	ated.
	Hos 24 h Fur letely	edicai	(Check only 2 Medical one)	Examiner: On the basis and manner	s of examination and/or in	vestigation, in my of	pinion, death occur	red at the time, dar	te and place, an	d due to	the cause(s)
	To the within 2 To the Comple	Me	29b. Signature and title of certific	ar /		29c. License	a number.	29	d. Date signed (	Month, L	Day, Year)
			Yaka	2		M DO	05/11	49	616	10	7
			30. Name and address of person	who completed cause of	of death (Item 23a) (Type,	Print) 1	1	1	-/.11	/	(
6	A/VA	(	davia Dima	near Mi	Dill Wes	+ High	St. Su.	te 305	2 Elktre	n	MD21921
V.,	Sta	te	31. Date filed (Month, Day, Year,	32. Pro	istrar's Signature	locate &		, , , , , ,			1
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 6/4/2007 17:59pM Robert James Johnson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Calvert Memorial Hospital Prince Frederick If Under 1 Year | If Under 24 Hrs. B. Date of Birth (Month, Day, Year) 1/25/1956 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days XXM 2 F 212-66-3919 Director Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 24s ~~~ any injury or other traumatic event. The Market once. 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 □Yes 2√□No Director MD Lothian Anne Arundel 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 20711 74 Edward Lane Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes XXX No Specify Specify: þ 3KXWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Paving 12 Salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nancy Smith Joseph James Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 74 Edward Lane Lothian, MD 20711 Mother Nancy Blush 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Metro Crematory 6/6/2007 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 1 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardio JespivaTo-/Medical Due to (or as a consequence of): **Examiner** Live Sequentially list conditions, Due to fur as a consecurior offi Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Thromboa attending physician and for use as the burial-tran Due to (or as a consequence of): 410 9600 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Jaundia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should Be Completed Failum 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 1∐ Yes 2 No 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: #
completely filled in by the fi 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Hospital or Attending Physician:

The law requires that the death certificate be executed

P.O. Box 68760,

Records,

this

Registrar

Medical

(Check only one)

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

RD

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier D 50290 Shal 3

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shah HOSP Dhirsen

ilo,

2067X

JUN 0 6 2007 31. Date filed (Month



Chauncy Harold Joi	1	For State	epart		th and		ygiene			7 2014
Physician/ Medical Examiner	1	gistrar Decedent's Name (First, Middle,Last)	Jr.			· · · · · · · · · · · · · · · · · · ·	2. Date of Dea Month May 28, 2	th		3. Time of Death 0300 hrs
¢''		4a. Facility Name (if not institution, give street and number)  Prince Georges Hospital Center  4b. City, Town, or Location of Cheverly				Location of Death	Death 4c. County of Dea Prince Georg			s
Funeral Director		Social Security Number 6. Sex 7. Age (In 7.7 – 9.4 – 5.4 0.3 1 X M 2 F 4.6		birthday) If Undo Month Yrs.	er 1 Year s Days		_	th(MM/DD/YYYY	Foreign	
the Maryland as or 28a-f show any stiffed at once,			10f. Zip Code			10g. Citizen of What U.S.A.		hat Count	10d. Inside City Limits 1 Yes 2 X No	
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Inportant: I fitten 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	-	1. Marital Status  X Never Married  2 Married  3 Widowed  4 Divorced  12 Was Decedent Eve Armed Forces?  1 Yes 2 X  15 Per States  15. Decedent's Education (Specify only highest grade complet  Elementary/Secondary (0-12)  College (1-4 or 5+)	13. Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Ric      1 Yes 2 No specify:      a. Decedent's Usual Occupation (Give kind of work during most of working life. DO NOT use retired)			work done	14. Race - American Indian, Black, White, etc.  Specify: black  16b. Kind of Business/Industry			
21215-0036 uld be filed within 72 hour Mental Hygiene. marked other than "natt revent, the Medical Exa		7. Father's Name (First, Middle, Last)  Chauncey H. Jones J  Ba. Informant's Name/Relationship (Type, Print)	<u> </u>	Contract  19b. Mailing Address		Glor	ia El	Maiden Surname lerbee	<b>;</b> )	ernment Zip Code)
altimore, MD mit. Pages I and 2 sho portunet of Health and portunet. If item 27 is ny or other traumati		Chaunetta Jones/ daughte  Ca. Method of Disposition  X Burial 2 Cremation 3 Removal from State  Donation 5 Other Specify:  1. Signature of Funeral Sec. & License.	20b. Pla cre	1 Marsha ice of Disposition (Nai matory or other place orge Wash 22. Name and	me of ce ) ning	ton 6	Date / 4 / 0 7	Irving 20c. Location Adelph al Mort	- City or T	Md.
Physician  Physician  /Medical  caminer		411 Kennedy St NW Washington, DC 2001  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart  Approximate Int								DC 20011 Approximate Interval Between Onset and
, P.O. Box 68760, res that the death certificate be executed signed by the attending physician and be detached for use as the burial - transit dby Physician/Medical Exa	;	Due to (or as a consequence of the consequence of t	of pregna	2 Fetal death		Ectopic pregr	nancy	23d. Date o		ay Year
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans Medical Certification: To Be Completed by Physician/Medical E	commence to be completed as	7. Manner of Death 1 Natural 5 Pending Investigation 28a. Date of Injury May 28, 2007 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Single 9a. Certifier 1 Certifying Physician: To the best of my known of the desis of examine (Specify) Single (Specify) Resident (Specify) Single (Specify) Resident (Specify) Resident (Specify) Resident (Specify) Resident (Specify) Resident (Specify) Single (Specify) Resident (Specify) Reside	2 ✔ E 2 (c - At home Famile	R/Outpatient 3 the last time of Injury 1200 hrs the, farm, street, factory by death occurred at the	26.Piacc	e of Death (Check Other'4 Nurs Iry at Work? Yes 2 No building, etc.	1 Ye  24a. Was auto perfic 1 Yes  conly one) ing Home 5  28d. Describe Subject sho  28f. Location or Town, 3611 24th St	Residence 6  Residence 6  how injury occur  (Street and Numt State) reet, Temple H  sse(s) and manner	Prob Were aut prior to co death?  1 V Ye  Other- rred  Other- rred	: ral Route Number, City ed.
or room	1	9b. Signature and title of certifier  O. Name and address of person who completed cause of death Susan Hogan MD. Assistant Medical Exan			O.C.	M.E.	1201	29d. Date sign	,	nth, Day, Year)
State Registra		Susan Hogan MD. Assistant Medical Exam  1. Date filed (Month Pay, Year) 7 2007 32. Registrar's S	Signature		)	ao.o, MD Z	.207			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2007 **Physician** Victoria Jones June 9 9:07P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince Georges If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 □ M 2 🕱 F 179-26-8830 75 Director Nov.9,1931 VA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XYes 2 No Director Md. Fort Washington PG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8004 Alcoa Drive 20744 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: Black ģ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elsie Unknown Clarence Gray ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8004 Alcoa Drive Fort Washington, Md. 20744 Elsie Mathis/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cem. 6/18/07 Clinton, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Colored Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Ather significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ History Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performe death? 1 ☐ Yes this certificate 2 **1** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 100 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral. 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signaturg and title of certifie

State Registrar 1501

who completed cause of death (Item 23a) (Type, Print)

AVE Size 3-41

32. Registrar's Signature

			= State Amend #2,5,	State of Mar 19a per PHY	yland / De S / Fh 06	partment of F 1572007 ertificate of	lealth and M Death	lental Hy	giene Reg. No.	7 20144		
	/sicia	ın	1. Decedent's Name (First, Middle, Last)  Edwin R. Kinsey, Jr.					2. Date of De	<b>6,2007</b> Yea			
Exa		er	4a. Facility Name (If not institution, giver 12121 Gladhill 5. Social Security Number 16.5	e street and number)  Brothers Ro	ad In yrs. last birthda 7 Yrs	Monrov  Monrov  If Under 1 Year  Months Days	If Under 24 Hrs.	8. Date of Bird (Month, Da Nov. 19	4c. County of De	eath		
Director			Usual Residence of Decedent  10a. State 10b. County	11	0c. City, Town or	Location		1011	, 1929 110	10d. Inside City Limits		
paritimion is interest, in the Maryland A. I.	ţo	Maryland Frederick Monrovia						1 ☐ Yes 2 XNo				
	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?			
	ral	12121 Gladhill Brothers Road				21770			S.A.			
	by Funeral Director	11. Marital Status  1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: K		3. Was Decedent of H If Yes, specity Cuba 1 ☐ Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes or No Rican, etc.)	. 14. Hace - Ar Black, W Specify:	merican Indian, nite, etc. White			
72 ho 72 ho natur dical		eted	15. Decedent's Education (Specify only highest grade completed)  (Give kind of work done during most of worki				ing	16b. Kind of Busines	•			
within ane.	e Me	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Wife. DO NOT use retired)  12 Owner-Operator					"" Gasoline Service Station				
filed v Hygie ther t		ပ္တို	17. Father's Name (First, Middle, Last	)	1 0	ior operat		e (First, Middle,	Maiden Surname)			
ld be dental	tlc eve	To Be	Edwin Reese Kin	sey, Sr.			Jane	Elizabe	th Ayton			
and N and N s mai	ınmai		19a. Informant's Name/Relationship (		Δ		and Number or Rur	al Route Numb	er, City or Town, State	e, Zip Code) 21770		
and and ealth m 27	er tra									, Maryland		
Daltillore Dermit. Pages 1 Department of H mportant: If iter	njury or oth		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Special	Removal from State	20b. Place of Dis cemetery, of Metropo	sposition (Name of rematory or other place Litan Crematory	atorium 6	/8/07	20c. Location - City Alexandria	or Town, State		
Deparmi Deparmi Impo	any Ir		21. Signature of Fun ral Service Lice	Will	inno	Moleswort	h-William	s P.A.,	Funeral H	ome d 20872		
	3	$\neg$	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between		
Physician		Ì	Immediate Cause (Final disease or condition resulting in death)  a. Congestive Heart Failure						Onset and Death  1 year			
/Medical Examiner		resulting in death)	Due to (or as a c	onsequence of):								
		ē	Sequentially list conditions, if any, leading to immediate	b. Anemia Due to (or as a c	1a (or as a consequence of):					6 months		
uted d ansit		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Indenying Cause (Disease or injury that initiated events									
cate be executed physician and	urial-tr	ᄶ	resulting in death) Last	Due to (or as a c	Due to (or as a consequence of):							
icate t	s the b	dical		_d								
ding Physician: The law requires that the death certificate be executed h. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	1 Il live hirth 2   Fetal death 3   Fetonic pregnancy						23d. Date of o	delivery Day Year			
	uld be deta	۵	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to						v			
The law restate has bee	page 2 sho	Completed						24a. Was autoj perfo 1∐ Yes				
VILC Ician: Sertific	ector,	Be	25. Was case referred to medical examiner?	Hospital:		tiant 30 DOA Oth	26. Place of Deat					
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stending leath. tor: Afte	e fune	tion	27. Manner of Death 1 Accident   28a. Date of Injury   28b. Time of Injury   28c. Injury at Work? 2 Accident   28d. Describe how injury occurred   28d. Describe how injury oc									
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t	ad in by the	Certification:	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of injury building, etc. (	- At home, farm, 'Specify)	street, factory, office		28f. Location ( City or To	Street and Number or wn, State)	Rural Route Number,		
e Hospit 24 hours 9 Funera	letely filk	Medical (	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
To th To th	сошр	Me	29b. Signature and title of certifier 29c. License number 29d. Date						29d. Date signed (Mo	ate signed (Month, Day, Year)		
	,		Bennett Monie M D47682 June						June 7,	e 7, 2007		
7418	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  20832  Bennett T. Morrison M.D. 2901 Olney-Sandy Spring Road, Olney, Maryland									
	Sta	te	Bennett T. Mo	orrison M.D. 32. egistrar's	Signature	Office - Sa	nay Sprin	g Koad,	Olney, N	lary⊥and		
Re	gistr	ar	THEN I 8 5	UU/ Come	Signature	Joseph						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Keller Charlyne Joyce 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MBL-RLAND I-GAR MEMORIA 8. Date of Birth (Month, Day, Year) Nov 4, 1936 Age (In yrs. last birthday, 5. Social Security Number Days Months 1 □ M 2 🙀 F ΜD 70 266-56-7716 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1√Yes 2 No Cumberland MD Allegany 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 USA 14510 Uhl Highway, SE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) First United Bank bank teller 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Myrl M. Zimmers Madeline Canan Zimmers Null 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14510 Uhl Highway. SE Cumberland MD 21502 19a. Informant's Name/Relationship (Type. Print) 14510 Uhl Highway, SE **Edward Keller** husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Rocky Gap Veterans Cemetery 6/20/2007 MD Flintstone 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Finaral Sando Dicert 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a, 2411. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) INTRACRANIAL HEMORRHAGE Due to (or as a consequence of) 5Tem MP21-551 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) HYPERTENSION Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Examiner

Physician/Medical

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Certification:

Medical

29a. Certifier

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or any injury or other traumatte event, the Medical Examiner must be Is any injury or other traumatte event, the Medical Examiner must be Is an injury or other traumatte.

Physician

/Medical

**Examiner** 

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Maryland 21215-0036

Baltimore,

Director

Funeral

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sician and burial-transit attending physician for use as the ed by the a

the death certificate be executed

Box 68760,

Division or Vital Records, P.O.

Attending Physician:

To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

State Registrar

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29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Ten of Maryand October 1868, 6/21 07 aws Mental Hygiene END ITEM#5, per FH C688, 6/20 Death, WS 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month KENNETH LOUGH 06 05 2007 LEE 0105 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS - MEMORIAL CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days | Hours | Min. | May 24, 6 Sex 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral 1X** M 2 □ F Maryland 71 Director filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at MD Allegany Flintstone 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21410 Flintstone Drive, N.E. 21530 USA Funeral 12. Was Decedent Ever 1959 Armed Forces? 1959 1 Tyes 2□ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify ۵ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Laborer Tire 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( Broze Lough Hilda Mae (Leasure) Lough 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret D. Lough Wife 21410 Flintstone Drive, N.E., Flintstone, MD 21530 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park June 8 07 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hafer Funeral Service, PA 21. Signature of Funeral Service Licenses any 1302 National Hwy., LaVale, MD 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ETASTATI /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an has autopsy performe this certificate 2 No 2 No 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 3□ DOA Certification: To 2 ER/Outpatient filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manper of Death 28b. Time of 28d. Describe how injury occurred Director: After 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Funeral 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature an 29c. License number 29d. Date signed (Month, Day, Year) 1041 Name and address of pe who completed cause of death (Item 23a) (Type 31. Date filed (Month, Day, 32 Registrar's Signature State Registrar

State Registrar

DHMH 17 Rev 1/2001

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32. Registrar's Signature

Mariasa

PENNSYLVANIA AVE HAGERSTOWN MO 21742

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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A STRAUSS

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** John J. Leyland June 2, 2007 2:30 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crownsville Fairfield Nursing Center Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 7/2/195 Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sax **Funeral** 1 ₹ M 2 □ F Yrs. 49 212-70-4958 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County or 28e-f show item 27 is marked other than "natural", or items 23a or 28e-1 shov other treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Directo Marvland Anne Arundel Crofton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2089 Jason Ct. 21114 USA Funeral 12. Was Decedent Ever in U.S. Agned Forces? 1 ∰ Yes 2 □ No If Yes, Give Year or Dates: 1976-80 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) 12th College (1-4or 5+) Mechanic Sheet Metal 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill timent of Health and Mental H lent: If item 27 is marked other Be Henry Joseph Leyland Mary Ouirk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Julie A. Keegstra/ Sister 2089 Jason Ct., Crofton, MD 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Department of H Importent: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 6/6/07 Edgewater, MD 21. Signatur of Juneral Service Ligensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Throa arcmama /Medical Due to (or as a consequence o Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Month Day ō in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9☐ Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕬 nknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ( No ) 24a. Was an certificate has blirector, page 2 s autopsy performed 21. No 1 ☐ Yes Attending Physicien: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Moursing Home 5 Residence 6 Other (Specify) 흔 1 ☐ Yes 2 No 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Avatural
2 Accident Injury 5 Pendina 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funerel Director: , completely filled in by the f 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D38958

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of perso

31. Date filed (Month,

Day, Year)

can & sport

Highway S. W

Glin Barnie MD 21061

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-04419 2007 20149 State of Maryland / Department of Health and Mental Hygiene Douglas Kent Lewis Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ June 9, 2007 0941 hrs Medical Examiner Douglas Kent Lewis 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Dundalk 2729 Liberty Parkway 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Country) 1957 Director Aug 30. 1 X M 2 F 49 Yes 161-48-4841 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 X Yes 2 No or items 23a or 28a-f show must be notified at once. Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code USA 21202 High Street 301 N. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. or items Armed Forces? 1 X Never Married 2 Married 1 X Yes Yes, Give Year Specify: Black Yes 2 X No specify Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", of injury or other traumatic event, the Medical Examiner I Widowed 4 Divorced ş 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Pages I and 2 should be filed within 72 hours 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 Home Care Elder Care 1 12 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elsie E. Williams Raymond Phillip Lewis Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 530 Las Rosas Drive, Kennett Sq, PA 19348 Gale Lewis 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) emoval from State 2 X Crematies 3 Chester Township. June 20,07 Other Specify: Crematory 22. Name and Address of Facility Congo Funeral Home e of Funeral Serl P.O. Box 2593, Wilm, DE 19805 aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a. Part f. Enter the disease, or complications that Physician Between Onset and failure. List only one cause on each line. Death √Medical Alcoholism Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit executed Physician/Medical X UNPENDED #23a,27,perME,g870, 8/2/07 TT attending physician or use as the burial law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23d Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Month Dav Year 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 y the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? 1 🗸 Yes No Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: 24 hours after death. Be examiner Residence 6 🗸 Other: Scene Hospital: Nursing Home 5 DOA Inpatient ER/Outpatient 3 this 1 Yes ٩ 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification: 1 X Natural within 24 hours after deam.

To the Funeral Director: A Yes 2 No Pending 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 10, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Margarita Korell MD. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			1 - For State Registrar	State of Ma	aryland	-	artment tificate			and M		iene () (	) 7	20150
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J.	res that t signed by be detac		Part II. Other significant conditions co	ontributing to death b	ut not resultir	ng in the u	nderlying ca	ause give	n in Part I		23e. Did to	bacco use cont	tribute to	the cause of death?
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	To the Hospital within 24 hours a To the Funeral I completely filled	Medicai (	(Check only 2 Medical Examone)	rsician: To the best iner: On the basis of and manner st	f examination	edge, death and/or in	vestigation,	in my op	oinion, dea	d place, th occurr	ed at the time, d	ate and place,	and due	to the cause(s)
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** JUNE 5018 HODE /Medical 4a. Facility Name If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MARY ALTIMOKE 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🛛 F Months Days Hours 78 Maryland 218-24-9291 July 5, Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic event. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2XXXVo Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 237 Winding Oak Drive 21740 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 Never Married 2 Married Yes 2 f Yes, Give 1 ☐ Yes XXNo Specify Completed by 3X Widowed 4 ☐ Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Seamstress Retail Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Franklin Baker John Alice 2 Rebecca Houser 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy McAllister - Sister 16612 Coney Court Williamsport, Maryland 21795 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Lurial 2 □ Cremation 3 Removal from State 5 Other (Specify) June 14,2007 Williamsport, Maryland 4 ☐ Donation Greenlawn Mem. Park 21. Signature of Funeral Se OSUMPNEAFIMEFEIN Home, P.A. 425 S. Conococheague St. Williamsport, Maryland Approximate Interval Between Onset and Death 23a. Part. Enter the Asease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart Milure. List only one cause on each line. Immediate Cause (Final **Physician** 3 MONT disease or condition resulting in death) /Medical Due to (or as a consequence f): Examiner Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∏ Yes 2 **1** No Be 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ပ 1 ☐ Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA After this . Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No after death.

Director: A 2 Accident investigation 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) onel within 24 29b. Signature and title of confifier 29d. Date signed (Month, Day, Year) ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add 22 31. Date filed (Month, Day, State JUN 1 2 2007 Registrar

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		4 Donation				Aı						9/2007	2. Date of Death Month  June  10  2007  3:30 A  4c. County of Death  St. Mary's  8. Date of Birth (Month, Day, Year) Oct.11,1924  10g. Citizen of What Country?  U. S. A.  City Yes or No-Rican, etc.)  16b. Kind of Business/Industry  Retail  (First, Middle, Maiden Sumame)  mek  17 Route Number, City or Town, State, Zip Code)  Rechanicsville, MD  20659  ate  20c. Location - City or Town, State  1 And Death  207 Arlington, Virginia  nsfield-Echols Funl. Hme., P.  Charlotte Hall, MD  20622  respiratory arrest,  Approximate Interval Between Onset and Death  Lun Known  23d. Date of delivery Month  Day Year  23d. Date of delivery Month  23d. Date of delivery Month  Day Year  24a. Was an autopsy findings available prior to completion of cause of death?  1 Yes 2 No  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  (Check only one)			nia	
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State Registrar 31. Date liled (Month, Day, Year) 32. Registrar's Signature

JUN 1 2 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Joseph Gustav Mason Jr. JUNE 200+ /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death DORCHE AMBRIDGE DRCHEST GENERA If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours Year, 1 X M 2 □ F 473-09-1170 **Director** 84 19 Feb. 1923 Minnesota Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or Items 23a or 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD Dorchester 1 XYes 2 No Director Cambridge 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 118 Willis St. 21613 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white þ 3 Widowed 4 Divorced WWII Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) writer magazine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be in nent of Health and Mental Joseph G. Mason Marguerite Ewald မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Mason son 701 Race St., Apt. 316, Cambridge, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important: If It any Injury or o 1 ☐ Burial 2XICremation 3 ☐ Removal from State Salisbury Crematory 4 Donation 5 Dother (Specify) 6/7/07 Salisbury, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to fo Examiner as a consequence The law requires that the death certificate be executed physician and the burial-trans that initiated events resulting in death) Last Due to (or as Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 ☐ Yes 2 No 3 Probably 4 Den mown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Yeo 24a Was an has page 2 certificate Vital 25. Was case referred to med c examiner? funeral director 26. Place of Death (Check only one 1 ☐ Yes 2 D Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: hpatient 2 ER/Outpatient 3□ DOA Certification: To 0 this 28a. Date of injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Hospital or Attending Division 1 Natural 5 Pending investigation hours after death.

uneral Director: A

sly filled in by the fu 2 Accident 1 Yes 2 No death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hours the Funeral Directory filled in by 4 Homicide The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 29b. Signature and Itle of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person wh completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

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31. Date filed (Month,

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 💆 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		_	e Hen			i	6-8-2	2007	Fra	nkford.	DE	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** Year 200 /Medical nty of Death 4a Fability Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Examiner If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) Months Year, 1 M 2 □ F Days Director tai Usual Residence of Decedent the Maryland 10a. State 10b. 10c. City, Town or Location 10d. Inside City Limits show r 28a-f sh notified 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 2 any highy or other traumatic event, the Menical Exercises on 2 once. 10g, Citizen of What Country? by Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SCAP Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be MORYIS ည nformant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route N mber, City or To wn, State, Zip Code) ena MD 2192 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition

1 Burial 2 Cremation 3 B

4 Donation 5 Other (Specify) 20c. Location - City or Town, State 3 Removal from State 8/07 ter Township, 124 22. Name and Address Facility 21. Signature of Funeral Service Licensee Fureral 2592 23a. Part : Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ach line. Immediate Cause (Final disease or condition resulting in death) **Physician** eporrotor /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine onsequence of) law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical as the for use IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death ed by the a detached f 5 Other (specify) 9 ☐ Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ been signature should to 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 autopsy certificate 2 No 1☐ Yes Physician; 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one, 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient ٩ 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 ☐ Pending investigation (Month, Day death. 1 🗌 Yes 2 No To the Hospital or Attend within 24 hours after death To the Funeral Director: the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who pleted cause of death (Item 23a) (Type, Print) mainst Elkon, mo MI 31. Date filed (Month, Day, Year) State Registrar

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To th within To th	dwoo	Me	29b. Signature and title of certifier		29c. License	50-17	4	9d. Date signed (Mor	
Re	Sta gistra		30. Name an address of per on who completed cau.  31. Date filed (Month, Day, Year)  32. JUN 0 8 2007	Ise of death (Item 23a) (Type,	Print)  . A.V.	JIM	18, 7	alivo,	und 2 1800

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Dorothy 5, Noves Augusta 2007 June 1:15 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Brooke Grove Nursing Home Sandy Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours 1 □ M 2 🛛 F 578-26-5881 82 Director Feb. 13, 1925 New York Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 □Yes 🛣 No Directo Maryland Montgomery North Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be 10724 Brewer House Road 20852 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any into other traumatic event, the Medical Examine any. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White ð 3 □Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Clerk Grocery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Swickert 2 Carol L. Matausch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert J. Noyes/Son 10724 Brewer House Road, North Bethesda, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State June 8, Gate of Heaven Cemetery Silver Spring, Maryland 4 Donation 5 Dother (Specify) 2007 22 Name and Address of Eacility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd, W, Silver Spring, MD 20901 Comes 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Atrial Fibrillation, Hypertension should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2 X No 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 🔼 Natural Injury 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D39793 June 6, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christopher J. Mays, M.D. 1811 Prince Philip Drive, Olney, MD 20832 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 0 200 Registrar

			1- State of Maryland /	Department of Health Certificate of Death		iene 007 20158
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) L/13BYE G. P.	RAWDE	2. Date of Death Month JUNE	Day 2 2007 6, 45PM
	Examin Funeral Director	er	4a. Facility Name (If not institution, give street and number)  HEBREW HOME OF GREATER WASHINGTON  5. Social Security Number  6. Sex 7. Age (In yrs. last.)  577-40-6957  101	Ab. City, Town, or Location  ROCKVILL  birthday)  If Under 1 Year   If Under 1 Months   Days   Hours	E or 24 Hrs. 8. Date of Birth	
		ctor	Usual Residence of Decedent	own or Location		10d. Inside City Limits 1 ⊠ Yes 2 □ No
1	s 23a or 28a-f s	eral Director	10e. Street and Number 6121 MONTROSE ROAD  11 Marrital Status 12, Was Decedent Ever in U.S.	10f. Zip Code 20852  13. Was Decedent of Hispanic O	U.	Og. Citizen of What Country?  S • A •  14. Race - American Indian,
999	natural, or Items 23a	d by Funeral	Armed Forces?  1 Never Married 2 Married I Yes, Give  3 XWidowed 4 Divorced Year of Dates:	If Yes, specify Cuban, Mexico	an, Puerto Rican, etc.) y:	Black, White, etc.  Specify: WHITE
201212		Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	6a. Decedent's Usual Occupation (Give kind of work done during mo life. DO NOT use retired)  MEMAKER	ost of working	16b. Kind of Business/Industry
yiais	z should be lifed willing and Mental Hygiene. is marked other than aumatic avent, ITE M	Be	17. Father's Name (First, Middle, Last) DAVID GOLDMAN	LIAH	YARLICK	
מ	Health Sm 27 ther tr		LINDA GOODSON/DAUGHTER 13  20a Method of Disposition 20b. Place	9b. Mailing Address (Street and Numi 3210 POINT PLEASAI of Disposition (Name of tery, crematory or other place)	NT DRIVE, FAI	
	Department of I		*4 Donation 5 Other (Specify) KING  21. Signature of Funeral Service Licensee	22. Name and Address of Faci EDWARD SAGEL FI	ility UNERAL DIRECT	
	hysician /Medical xaminer	31	23a. Part 1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate  Due to (or as a consequence)	L HYPERTE GIA	s cardiac or respiratory arre	
,00,00	to the troping of the death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the consequence	e of):		
٠ •	y the attending packed for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 10 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown			23d. Date of delivery Month Day Year
olds, r	been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting CEREBRAL ANEL	g in the underlying cause given in Part	1	
יין ויין	sertificate has b irector, page 2 sh	e Completed	25. Was case referred to medical	26 Pla	24a. Was ar autops: perform 1 Yes 2	prior to completion of cause of death?  1 Yes 2 No
	Attending Frigstalan. The st death.	Certification: To B	examiner?  1	Outpatient 3 DOA Other: 4 7  Time of Injury M 1 Yes 2	Nursing Home 5 Reside 28d. Describe ho	nce 6 Other (Specify)
	in the Proposal of Area of the Willing 24 hours after death.  To the Funeral Director: After completely filled in by the funer.		4 Homicide determined 236. hate of my Annual Substitutions.  29a. Certifier 1 Cartifying Physician: To the best of my knowled	ige, death occurred at the time, date a	City or Town	, State) tuse(s) and manner as stated.
To also the	within 24 hours after to the Funeral Director completely filled in	Medical	(Check only 2 Madical Examinar: On the basis of examination one) and manner stated.	and/or investigation, in my opinion, de	eath occurred at the time, da	ate and place, and due to the cause(s)
5	= 22 -		30. Name and address of person who completed cause of death (tern 23)  31. Date filed (Month Pay, Vear)  2007  2007  2007  2007  2007  2007	a) (Typa-Print) MONTRU	SEED. PECE	LVILLE, MD 20852
	Sta Registr		31. Date filed (Month Pay, Year) 32. Trigistrar's Signature	AND I		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Physician Month Year 1835 ALAIGUS 06 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 2157 Scotts Crossing Court #104 Annapolis Anne Arundel .Sex 1MM 2□F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 069-16-4631 84 Director Sept. 4, 1922 New York Usual Residence of Decedent 10a. State show 10c. City. Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at Maryland Anne Arundel Annapolis 1 □Yes 2√No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2157 Scotts Crossing Court #104 21401 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. within 72 hours after NOYes 2 No NYes 2 No NYes 1942–45 Year or Dates: 1942–45 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes XXNo Specify. White <u>Ş</u> Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner Billiard Hall rmit. Pages 1 and 2 should be filed vapartment of Health and Mental Hygis portant: If item 27 Is marked other vy Injury or other traumatic event, # marked other alth and Mental Hv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony Palaiologos Melpo Berbakos 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Pappas Palaigos/wife 2157 Scotts Crossing Court #104 Annapolis, MD 21401 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or Demetrius Cemetery 6/8/2007 Annapolis, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21 Signature of Funeral Service Licensee Tuels 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed burial-transit Exami Due to (or as a consequence of): physician Physician/Medical the as IF FEMALE: use If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death Day Year 5 Other (specify) the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy perform certificate 1∐ Yes 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 1 Residence 6 ☐ Other (Specify) 200 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Medical Certification: Hospital or Attending (Month, Day Year) 1 Natural 5 Pending ithin 24 hours after death.

b the Funeral Director: A

mpletely filled in by the fu death. investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 24

Division or Vital Records, P.O. Box 68760,

State

31. Date filed (Month, Day, Year,

Chief Medical Officer

JUN 0 6 2007

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mul

Michael J. LaPenta, M.D.,

29d. Date signed (Month, Day, Year) Jun, 01

200

Hospice of the Chesapeake, 445 Defense Highway, Annapolis, MD 21401

Registrar

29c. License number

D 21438

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dav Jero1d Clair Parish June 11, 2007 2:35 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 41695 Laverne Lane Leonardtown St. Mary's 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 XM 2 ☐ F Director 299-36-7800 03/05/1942 Ohio Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director Maryland | St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 41695 Laverne Lane 20650 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ YNo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after in nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural"; or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: à Specify. 3 ☐ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Project Manager Electrical Contracting Item 27 is marked other other other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Clair Allen Parish Helen Kroetz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth P. Dorr/Daughter 41695 Laverne Lane, Leonardtown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Township Cem. 06/16/2007 Luckey, Ohio 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kyle S. Simons M01206 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician METASTATIC NONSMALL CELL LUNG CANCER 15 months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No page 1□ Yes certific 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA æ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 \(\hat{\text{Accident}}\) Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Funeral C 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 50 68 6 6/11/ 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.O. BOX 527 Chabia town md rileep Loncyci 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State Registrar 2007

			CATA	partment of Health and N	∕lental Hyg	jiene	
			Registrar	ertificate of Death		Reg. No.	20161
	Physici	an	Decedent's Name (First, Middle, Last)		Date of Dea    Month	Day Year	3. Time of Death
	/Medic		Alfred Murvin Purdy, Jr. 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	June	11, 2007	2:05 P <sup>M</sup>
	Examir	er	47843 Yaocomico Drive			4c. County of Death	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)		8. Date of Birth	St. Mary	lace (State or Foreign
П	Director		578-36-9977 1\(\mathbb{X}\) M 2□F 76 Yrs.	Months Days Hours Min.	(Month, Day 07/17/1		ington, DC
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or 1	ocation			
	Aaryla f sho ed at	ō	W 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2			10	0d. Inside City Limits 1 ☐ Yes 2 No
	the 28a-	Director	Maryland St. Mary's St. Mary	y's City 10f. Zip Code	1	10g. Citizen of What Count	
	h with		47843 Yaocomico Drive	20686			•
	death	Funeral		B. Was Decedent of Hispanic Origin? (Sn.	ecify Yes or No-	United State	an Indian,
92	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	y Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	If Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ☒ No Specify:	Hican, etc.)	Black, White, e	
21215-0036	hours ural",	d by	3 X Widowed 4 □ Divorced Year or Dates:			Specify: Whi	
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פָׁכ	e filec al Hyg othe /ent,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, I		111
/lar	uld by Ments Irked Itic ev	To E	Alfred Murvin Purdy, Sr.	Carrie A	Alice Pu	mphrev	
Maryland	2 sho and 1 Is ma auma		19a. Informant's Name/Relationship (Type. Print) 19b. Mai	iling Address (Street and Number or Run			Code)
	and lealth m 27 her tr		Lynda Purdy/ Daughter 1833	7 Hartman Drive, S	t. Mary'	's City, Mar	yland 20686
Baltimore,	iges 1 nt of F if ite or ot		20a. Metrod of Disposition 120b. Place of Dist	consition (Name of permatory or other place)	Date	20c. Location - City or Tox	wn, State
量	it. Pa intmer intant: njury		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	ld-Echols Cr. 06/13	3/2007 C	Charlotte Ha	11, MD
Ba	Depa Impo any I		Vivila C. Cimara Moligar	22. Name and Address of Facility Bri	nsfield	Funeral Hom	e, P.A.
			23a. Part1. Enter the disease, or complications that caused the death. Do not en	2955 Hollywood Roa	d, Leona	<u>irdtown, M</u> ar	vland 20650 Approximate
	Physician		shock, or neart failure. List only one cause on each line.			,	Interval Between Onset and Death
	/Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	11 Caranoma	STTAR	-lung la	months
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58760,	icate be executed physician and s the burial-transit						
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Box	death certifi attending   I for use as	2	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy			23d. Date of deliver	v
	The law requires that the death certif te has been signed by the attending age 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month [	Day Year
<u>Р</u>	at the de	Phy	9 LI OTIKITOWIT				
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Records,	sician: The law certificate has b irector, page 2 s	m m		-	24a. Was ar autops perforn	sy prior to com	sy findings available ipletion of cause of
Vital			25. Was case referred to medical		1□ Yes 2	2☐No 1☐Yes 2	2 🗌 No
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ō	g Physer this leral di	$\vdash$	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at		ence 6 □Other (Specify) ow injury occurred	}
Division or	ath. or: After ne funer	atjo	1 DrAatural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	M 1 □ Yes 2 □ No			
<u>S</u>	after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, si building, etc. (Specify)	treet, factory, office	28f. Location (Sti City or Town	reet and Number or Rural n. State)	Route Number,
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	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	edical	29a. Certifier  (Check only one)  2□ Medical Examiner: On the basis of examination and/or in the part of the basis of the part of the par	th occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the ca red at the time, da	ause(s) and manner as sta ate and place, and due to	ated. the cause(s)
)	omple	Med	29b. Signature and title of pertife	29c. License number		9d. Date signed (Month, D	
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		}	30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)		W 13-4	
			JiScott Tubill MO 23415	Print) Three Notch R	d Suite	2 2054 Calil	ama, mo
	Sta		31. Date filed (Month, Day, Year) 32. Hegistrar's Signature				9-10/-
	Registra	IF.	JUN 1 4 2007				

Please Type or Print in Black Indelibie Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. ( 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 13, 2007 7:32 <u>June</u> Robert Newton Ray /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days 1 MM 2 □ F Director 03/03/1919 Maryland 579-14-3837 88 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland St. Mary's Hollywood 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 45325 Daniels Road 20636 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event, the Medic once. College (1-4or 5+) Elementary/Secondary (0-12) Field Engineer Communications 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Henry Ray Laura Collison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 45325 Daniels Road, Hollywood, Maryland 20636 ce of Disposition (Name of Date 20c. Location - City or Town, State Betty D. Ray/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Macremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cr.06/15/2007 | Charlotte Hall, MD 22 Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 22955 Hollywood Road, Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** AYERHYTHMIA TIMUTER /Medical Due to (or as a consequence of): YFARS Examiner CORONARY Sequentially list conditions Se pentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) YJEARS MARENES attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐Yes 2☐No 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 1 🔲 Inpatient 2 ►R/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier within 24 ho

To the Function

completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25500 MO 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

JUN 1 4 2007

**ORIGINAL** 

			1 - For State Registrar		State of	of Maryla		artment of H rtificate of L			iene	007	20163
			1. Decedent's Name (First,	Middle, Last	)					2. Date of Deat	h		3. Time of Death
	Physici /Medio		Johnny R. Ri	ce						Month 6	Day 7	2007	1:45 P M
Day	Examir		4a. Facility Name (If not inst	itution, give	street and nu	ımber)		4b. City, Town, or	Location of Death	1	4c. Co	ounty of Death	
			Atlantic Gen	eral H	lospita	11		Berli	.n		,	Worcest	er
	Funeral	ŀ	5. Social Security Number	6. Se	x ]M 2□F	7. Age (In yı	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	olace (State or Foreign ntry)
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	land		10a. State 10b. Co			10c.	City, Town or Lo	cation					10d. Inside City Limits
	Mary -f sh	ğ	MD We	orcest	0.10		Occan C	- + - · ·					1 ☐ Yes 2 ☑ No
	128a	Director	10e. Street and Number	TCEST	.61		Ocean C	10f. Zip Code		1	0g. Citize	n of What Cou	ntry?
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9	72 hours after death with the Maryland Instural', or teme 23a or 28e-f show diest Examinar must be notified at	Completed by Funeral	1 Never Married 2	Married	Armed Fa 1 ☐ Yes If Yes, G	2 🗌 No	ì	fYes, specify Cubai 1 □ Yes 2 ⊡xNo	n, mexican, Puero Specify:	o Rican, etc.)		Black, White,	etc.
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12	within nne. then	dm	Elementary/Secondary (0	12)	College (	1-4or 5+)	}	DO NOT use retired,	)		П.	/m 1:	
D	Hygie ther int,	ပိ	17. Father's Name (First, Mi	ddle. Last)		4	Fun	draiser	18 Mother's Nam	ne (First, Middle, M			e Departmen
aŭ	d be entat	o Be	William Rice	,,					Gladys				
₹	shout nark mark	၉	19a. Informant's Name/Rela	tionship (T	rpe, Print)		19b. Mailin	ng Address (Street a			City or T	own State Zir	Code)
Maryland 21215-0036	od 2 st lith ar 27 is r trau		Sally Rice /					A 136th S					, 6000)
ē,	f Hea f Hea ftem othe		20a. Method of Disposition			20b	. Place of Dispo					tion - City or To	own, State
Ē	Page lent o nt: If ry or		1 ☐ Burial 2 ☐XCrema 4 ☐ Donation 5 ☐ Oth		Removal from			lopen Cre	1	/2007	Fran	nkford,	DE
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mentat Hygiene. Important: If Item 27 is marked other than "natural", or terms 23a or 28a-f show any injury or other traumatic event, Ita Medical Extending Important to not the profitted at any injury or other traumatic event, Ita Medical Extending Imports.		21. Signature of Funeral Se	vice Licens	88	1	_	. Name and Addres					
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П			23a art1. Enter the disease shock, or heart failure.	e, or complist only o	ications that	caused the de each line.	eath. Do not ent	er the mode of dying	, such as cardiac	or respiratory arre	est,		Approximate Interval Between
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	/Medical Examiner		resulting in death)		Due to	(or as a cons	equence of):						
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	xecur and al-trar	Examiner	that initiated events resulting in death) Last		Due to	(or as a cons	equence of);					-	
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ŝ	Se C 90		Part II. Other significant co	naitions co	tributing to d	leath but not r	esulting in the ur	nderlying cause give	n in Part I.	23e. Did tob			he cause of death?
Ö	w require been sign	etec								1,210	5 2	40 3 E FIOL	pably 4 Unknown
3ec	hast ye2s	Completed								24a. Was ar autops perforn	/		psy findings available mpletion of cause of
ā	n: Th licete r. pag									1 □ Yes 2	No No	1 🗆 Yes	2 No
⋚	Physician: The la rr this certificete has aral director, page 2	Be	25. Was case referred to me examiner? 1 ☐ Yes 2 X No	_	lospital:		CERIO	. 2 DOA Othe	-	th (Check only one			
ő	Phy or this oral d	7: To	27. Manner of Death	-	28a. Date	of Injury	☐ ER/Outpatien 28b. Time of	28c. Injury Work	4   Nursing In	ome 5 Reside			ý)
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			30. Name and address of pe	rson	m leter cau	se of death /lt	em 23a) (Type	Print)	- 112-1	- '		,,0	
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DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** Joseph R.  $a^{M}$ Skrinjar 5. 2007 11:25 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Bedford Court Assisted Living If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral**  Date of Birth (Month, Day, Year) Months Days Hours Min. 1 X M 2 □ F 8, Director 187-01-9911 88 1918 Pennsylvania Aug. Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 20906 USA 3701 International Drive, Apt. 729 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1941 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 🖳 No Specify SpecifyWhite 3 ☐ Widowed 4 ☐ Divorced 1941-45 Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) County Court Clerk permit. Pages 1 and 2 should be filed. Department of Health and Mental Hyg Important: if item 27 is marked other any injury or other traumatic event; 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Skrinjar Anna Pavlokovich 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 20906 19a. Informant's Name/Relationship (Type. Print) 3701 International Drive, Apt. 729, Silver Spring, Anna P. Skrinjar/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State June 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 Donation 5 Other (Specify) 2007 Silver Spring, Maryland 21. Signature of Funeral Service Licenses Francis Address Corillins Funeral Home Inc. 500 University Blvd, W, Silver Spring MD 20901 Owns 23a. Part1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Less than 6 Alzheimer's Dementia /Medical Due to (or as a consequence of) months Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transi and Due to (or as a consequence of). Box 68760, attending physician certificate be Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. Yes 2 No 9□Unknown 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ Lung Cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed ceen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has N autopsy page death? 1 ☐ Yes performed? certificate 1∐ Yes 2√√No 2 No Physician: dire tor, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Assisted 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Living 28d. Describe how injury occurred 28c. Injury at Work? Division To the Hospital or Attending 1 XNatural 5 Pending investigation

Certification:

thin 24 hours after death.

the Funeral Director: After the mpletely filled in by the funeral within 24 hours a

0+1

State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

2 Accident

4 Homicide

3 ☐ Suicide

29a, Certifier

0 7 2007

6 ☐ Could not be

determined

((

and manner stated

29c. License number D50545

1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) June 6, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30 Name and andress of person who completed cause of death (Item 23a) (Type Brint)
GODSWIII OKOJI, M.D. 7513 New Hampshire Avenue, Takoma Park, MD 20912

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM: 10a-c 10e f per TNF, C869, 7/10/07 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 12:45 P<sup>M</sup> Tommy Shen 06 04 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Hospital Montgomery Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**⊠** M 2□ F Director 82 114-30-2577 06/05/1924 China Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at Rockville Montgomery 1 ☐Yes 2X No Funeral Director 10g. Citizen of What Country? Dubuque Court USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married Specify: Asian 1 ☐ Yes 2 🛣 No Completed by 3 ☐ Widowed 4 💆 Divorced permit. Pages 1 and 2 should be flied within 72 he Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "naturany Injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Bellman Hotel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Unknown ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code)
Potomac Falls 19a. Informant's Name/Relationship (Type. Print) 20682 Reserve Falls Terrace #104, VA 20165 Jennifer Ky/ Friend Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 6/10/07 Falls Church, VA 21. Signature of Funeral S rvice License 22, Name and Address of Facility 7482 Lee Hwy 22042 National Funeral Home, Falls Church, VA Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia weeks /Medical Due to (or as a consequence of): Examiner Emphysema 2 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician the for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 4☐Pregnant at time of death as Leen signed by 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atrial Fibrillation 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No Diabetes Mellitus 24a. Was an autopsy p de certificate 1∐ Yes 2⊠ No Physician: After this certification, funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 X Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

State

Registrar

29b. Signature and title of certifier

L.

Nelson

31. Date filed (Month, Day,

Unlsouprisons, PHYSICIAN

Refistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

Lui,M.D.

DHMH 17 Rev 1/2001

D43869

11908 Darnestown Road, Suite D, N. Potomac, MD 20878

29d. Date signed (Month, Day, Year)

06-04-2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Time of Death Dav **Physician** Year 12:10 a<sub>M</sub> Ruth Shartsis June 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4514 West Virginia Avenue Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 M 2 X F Yrs. Director 220-44-6437 January 29, 1911 New York Usual Residence of Decedent 10a. State 10c, City, Town or Location 10b. County 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐Yes 2 No Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a 4514 West Virginia Avenue 20814 U.S.A. 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No þ Specify: 3 Nidowed 4 Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "! amy injury or other traumatic event, the Med once. Elementary/Secondary (0-12) College (1-4or 5+) 1 Dental Hygienist Oral Health Care Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacob Shartsis Annie Fisher ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jack Shartsis - Son 12923 Lincoln Drive, Huntington Woods, MI 48070 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Mt. Lebanon Cemetery 6/7/2007 Adelphi, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Na 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician disease or condition resulting in death) Cardiopulmonary Arrest /Medical Due to (or as a consequence of) Examiner Coronary Artery Disease 10 years Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ner the death certificate be executed Physician/Medical Exami that initiated events resulting in death) Last attending physician and for use as the burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🗷 No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 01d Age 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Seizure Disorder 24a. Was an Hypertension 1□ Yes 2**X** No or Attending Physician: in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification; To 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide filled 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Hospital within 24 hours a

To the Funeral I To the

> Deena J. Shapiro, M.D., 10810 Connecticut Avenue, Kensington, Maryland 32. Registrar's Signature 2007

and manner stated

Shapurs

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Meena

29c. License number

D35336

29d. Date signed (Month, Day, Year)

June 5, 2007

			1 - For State Registrar	State o	f Marylar			nt of H te of L		ınd M	lental		iene () (	) 7	201	63
***	Physici	an	Decedent's Name (First, Middle, Last,		_						2. Date of Month	1	Day	Year	3. Time of	
	/Medi	cal	Dorothy Schlaich  4a. Facility Name (If not institution, give				4b. City	. Town, or	Location of	f Death	June	2,	2007 4c. Count	of Death	8:45	A
4 4	Examil	ier	Genesis Eldercare		,		1 '		na Par				Anne			
	Funeral		Social Security Number     6. Security Number	M 2(X) F	7. Age (In yrs. 82			er 1 Year	If Under 2 Hours		8. Date of	of Birth		9. Birth	place (State o	or Foreign
şi.	Director		Usual Residence of Decedent	JW 2141	02	Yrs.					5/2	2/19	925	Ten	nessee	!
	yland		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation								10d. fnside Ci	
	B Mac	ctor	Maryland Anne Ar	unde1		Edgewat	ter								1 🗆 Yes	2 <b>X</b> No
	or 28	Dire	10e. Street and Number	_			10f. Z	ip Code				10	g. Citizen of		ntry?	
	s 23a	erai	540 Bay View Poin		edent Ever in U	16 12	Was Das	2103		i=2 /Sa	adı Van	- No	USA		can Indian,	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-1 ehow erry injury or other traumatic event, it is Modified Examiner must be notified at ODGE.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	Armed Fo 1 Tes If Yes, Giv Year or D	rces? 2 M No			77	spanic Orig n, Mexican Specify:	Puerto	Rican, etc	:.)	Bla	ck, White	etc.	
Maryland 21215-0036	hin 72 ho	Completed	15. Decedent's Edu (Specify only highest grad		1-40r 5+)	16a. Dece (Give life.	kind of w	ual Occupa ork done d use retired,	urina most	of worki	ng	1	6b. Kind of 8	lusiness/lr	ndustry	
2	ed with	Com	12th			Budge	et Ar	alys	t				Bureau	of (	Census	
and a	be fill d oth	Be	17. Father's Name (First, Middle, Last)  Karl L. Schlaie	c b							(First, M. Mae		faiden Surnar	ne)		
<u>~</u>	hould d Mer marke matic	ဥ	19a. Informant's Name/Relationship (Ty	2.72		10b Mailie	a Addras	c (Stroot a					City or Town	State 7	n Codel	
<u>⊠</u>	nd 2 suith an 27 is i		Glenn C. Schneider												nd 2103	37
ore,	of Head of Head fitem r othe		20a. Method of Disposition 1  ☐ Burial 2 ☐ Cremation 3 ☐ F	lamaval from	20b. I	Place of Dispo	sition (Namatory or	ume of other place	e) !		ate	2	20c. Location	· City or T	own, State	
Ĕ	Pagiment tant: Flury o		4 Donation 5 Other (Specify)		MD	Vetera							helten			
Baltimore,	Departimonal Importions once.		21. Signatur 1 Funeral Service Lipens	2											ral Hom D 21037	
8/60,	Physician /Medical Examiner  but style printing the print	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (	or as a consector or a consector or as a consect	quence of):	A1:	zhe	rim	er	`S: (	de	ment	Da	Onset and I	_
O. BOX 6	death certif e attending d for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Mo 9 ☐ Unknown	1 Live b	come of pregna pirth 2 Peta pant at time of cown	al death 3	Ectopic	pregnancy						ate of deliv		Year
rds, P	quires that n signed b	þ	Part II. Other significant conditions con	ntributing to de	eath but not res	sulting in the u	nderlying	cause give	n in Part I.				acco use con s 2□No	tribute to	the cause of d	death?
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ō	D = 0	n: To	27. Manner et Death	28a. Date	of Injury	28b. Time of		28c. Injury	at				nce 6 □Oth w in∤ury occur		<i>fy</i> )	
Ö	tending death. tor: After the funer	atio	1 turaf 5 Pending 2 Accident investigation	(MOIII	th, Day Year)	fnjury	М	Work 1 □ Y	es 2□N	10						
DIVISION OF		Certification:	3 Suicide 6 Could not be 4 Homicide determined	buildi	of Injury - At h ng, etc. (Speci	fy) 					City o	r Tówn,	State)		al Route Num	ber,
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in the formal or	edicai	29a. Certifier 1 Certifying Physical Conditions 2 Medical Examiliations	ner: On the ba	asis of examina	owledge, death	h occurre vestigatio	d at the tim n, in my op	e, date and inion, deat	d place, h occurr	and due to	the ca	use(s) and m te and place,	anner as s	stated. o the cause(s	;)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manf	ner stated.		29	c. License	number			29	ld. Date signe	ed (Month,	Day, Year)	
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<b>a</b>	/ /		30 Name and address of person who ec	mpleted caus	e of death (Iter	т 23а) (Туре,	Print)	11		11-	11		11		00	
۷.	HT ID		Unniter Kiedi. 31. Date filed (Month, Day, Year)	nger 32. A	e strar's Signa	eter	ans	1/U	14/	VL	Usr	SVI	ue	M	) 2//	108
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			State of Maryland / Department of Health and M  1- State Registrer Certificate of Death	, ,	ene 07	20169
	Physici	an	1. Decedent's Name (First, Middle, Last)  ANN MARIE SCHVSTER	2. Date of Death Month		3. Time of Death
>	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	<i>a</i>	4c. County of Dea	th
	Funeral		5. Social Security Number 6. Sex / PAge (In yrs. last binthday) If Under 1 Year If Under 24 yrs.	8. Date of Birth	FREDER 9. Bir	thplace (State or Foreign
	Director		195-20-1401 1 M 2 F 79 Yrs. Months Days Hours Min.	(Month, Day,	28	Pa.
	ehow	-	10a. State 10b. County 10c. City, Town or Location Md. Frederick Brunswick			10d. Inside City Limits
	n the M	Director	10e. Street and Number	10	g. Citizen of What Co	
	eath wil	Funeral D	157 FLONA Way 21758  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spi	acifu Yes or No.	14. Race - Ame	erican Indian
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "neturel", or Items 23s or 28s-f show supinjury or other treumatic event, the Madical Examinant Landillish at ODGe.	by Fun	Armed Forces? If Yes, specify Cuban, Mexican, Puerio	Rican, etc.)	Black, Whit	
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Maryland 21215-0036	be filed hat Hyg ed other event,	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name  Mayage	1		
aryle	should and Mer marke	P.	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rura	A 1191		Zip Code)
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Balt	permit. Departrimportri		21. Signature of Funeral Service Licensee  22. Name and Address of Facility 6 A  10 WEST SOUTH 5T	RY L.	ROLLINS F	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death
a state .	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):			Onset and South
ı	Examiner	).	Sequentially list conditions, if any, leading to immediate  b. Esphaceau Dysmotiuty  Due to (or as a consequence of):			
	acuted ind transit	Examiner	cause, Enter Underfying Cause (Disease or injury that initiated events  c			
8760,	icate be executed physicien and s the burial-transit	dical Ex	Due to (or as a consequence of):			
9	leath certificat attending phy I for use as th	/Medi	IF FEMALE: 23c. II yes, outcome of pregnancy			
O. Box	The law requires that the death certificate be executed tie has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Me	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No		23d. Date ol de Month	Day Year
<u>a</u> .	res that the de lgned by the a be detached t	by Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
Records,	w require been slg should b	eted b	CONCESTIVE HEART FAILURE	1 ☐ Yes		robably 4 Unknown
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Vital	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital: Hospital: Other Company of the company of	(Check only one	)	
0	Phys this raldi	on: To	1 Inpatient 2 EH/Outpatient 3 DOA Nursing Ho	me 5 Resider 28d. Describe how	nce 6 Other (Spe v injury occurred	icify)
Division of	Attending or death.	Certification:	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, larm, street, factory, office		eet and Number or R	ural Route Number,
á	a # in in			City or Town,		
	To the Hospital within 24 hours a To the Funerel Completely filled	Medical	29a. Certifier  (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the car red at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To t To tl	Σ	29b. Signature and title of certifier  29c. License number	30	d. Date signed (Mon	
1	5		30. Name and advess of person who completed cause of death (Item 23a) (Type, Print)	7	WE6,20	0 /
	Sta	te	ANDREW GILAS APERO VA  31. Date liled (Month) Pry. Year) 2007 32. Degistrar's Signature			
	Registr		WOM U & 2001 Bleene It Specking			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Year DAVID SEARS 2007 UNE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DORCHESTER CAMBRIDGE DORCHESTER GENERAL HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Director 217-05-2286 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the <u>Medical Examiner must be notified at</u> Director MD Dorchester Taylors Island 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4521 Hooper Neck Road 21669 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □X\*es 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Specify: 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) communications 8 maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Edwin Sears ပ Sara Violet Kiefer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Lambdin Jr stepgrandson 417 Hillsmere Drive, Annapolis, MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pages 1 Department of P Important: If Ite 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Brick Churchyard 4 ☐ Donation 5 ☐ Other (Specify) 6/8/07 Taylors Island, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Thomas Funeral Home P.A. k. R 700 Locust St., Cambridge, MD Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CHRONIC OBSTRUCTIVE PULMONARY disease or condition resulting in death) 20 415 /Medical Due to (or as a consequence of): Examiner Pherwdnia days Sequentiary list ou dillors, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) certificate be executed and physician ar s the burial-t Due to (or as a consequence of): Box 68760, Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. signed by the a ☐Yes 2☐No 9 Unknown 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♣ No has autopsy performed? res 2 No page certificate 1∐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 M Natural within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

31. Date filed (Month, Day, Year)

JUN 0 7 2007

30 Name and address of person who completed cause of death (Item 23a) (Type, Print) JAILALL MO 503 strar's Signature 32 B

M. D -

D65064

CAMBRIDGE MO

6-2007

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	/Medica	al .	Frances Cat										June			2007	1328	М
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2	Hygie ther i	ပ္သိ	17. Father's Name (First, M.	iddle, Last)	<u>+</u>		ne	men	lakel		18. Moth	er's Nam	e (First, Middle	e. Maiden			2	
<u>a</u>	id be ental ked o	To Be	Albert Andre		2						Catl	heri	ne Fran	ces	Zan	Sant		
Maryland 21215-0036	shound M		19a. Informant's Name/Rela	<del></del>			19b	Mailing	g Address	(Street a	and Numb	er or Rui	al Route Numi	ber, City o	or Tow	m, State, Zip	Code)	
Ž	and 2 alth a 127 is		Tia M. Eichh	orn/Da	aughter							е, Не	bron,	MD 2	183	0		
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 X Crema	ation 3 🗆 E	Removal from	State	20b. Place of cemeter	Dispos y, crem	ition (Nan atory or o	ne of ther plac	a) !		Date	20c. Lo	ocatio	n - City or To	own, State	
Ĕ	Pag ment lant:		4 Donation 5 Oth			2	Cremator	-				6/3/2				, Dela	aware	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene important: if item 27 is marked other than "netural; or itema 23s or 28s-1 show important: if item 27 is marked other than services. Examinar must be notified at once.		21. Signature of Furieral Se	ervic dio de	00	000	2010	Ze.	Name an IIer	Fune	s of Facil	Home	, P. O.	Вох	3	171		
	40204	1	23a. Part . Enter the disea	se or compl	ications that	caused the	e death Doir	12.	12 01	.d Oc	cean	City	Road,	Sali	Lsbı	ury, M	D 2180 Approximate	
	Dhaminina	4	slock, or heart failure Immediate Cause (Final	List only	ne cause on e	each line.					1			ui100t,			Interval Bet Onset and I	veen
	Physician /Medical		disease or condition resulting in death)		a	(or asa co	onsequence	af):	NE	19-		Col	aze			- 9	reas-	7
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	ъ <del>н</del> .	ne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	2		(or as a co	onsequence	of):								1		
	ate be executed hysicien and he burial-transit	Examiner	that initiated events resulting in death) Last	1	c. Due to	(or as a co	onsequence o	of):	_									
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X	anding use a	Z	IF FEMALE: 23b. Was decedent pregna	nt 2	23c. If yes, ou		oregnancy Fetal death	2 🗆							23d. [	Date of delive	эгу	
ω.	death	SICIA	in the past 12 months' 1 ☐ Yes 2 ☐ No	?		ant at tim	e of death		Ectopic pr Other (sp						N	Month	Day Y	'ear
P.O	res that the death certifica igned by the attending ph be detached for use as it	by Physician/Med	9 Unknown			_							1					
Division of Vital Records, P.O. Box 68	ires the signer		Part II. Other significant co	nations co	ntributing to a	eath but n	ot resulting in	the un	derlying c	ause give	en in Part	1.				/	ne cause of do eably 4 □U	
Ö	w require been signatured should b	Completed																
Rec	has ge 2 s	ם											24a. Wa auto perf	s an opsy ormed?	246	o. Were auto prior to co- death?	psy findings a mpletion of ca	available ause of
<u>e</u>	ificate or, pa	င်	25. Was case referred to m	edical							OC Plan	a of Doot	1 ☐ Yes	2 100		1 🗆 Yes	2 No	
Ξ	ysicia	0 0	examiner? 1 Tes 2 No	-	Hospital:	Inpatient	2□ER/Ou	tpatient	3 DO	A Othe		/	me 5 ☐ Res		6 □0	ther (Specif	v)	
2	ter th	Ë	27. Manner Death	landin n	28a. Date (Mon			ime of		8c. Injury Work			28d. Describe				,,	
<u>.</u>	endir eath. or: Af	Sation	2 Accident in	ending evestigation ould not be				,,	М		Yes 2 □	]No						
Ξ	or Att	Certification;		etermined	28e. Place build	of Injury ing, etc. (S	<ul> <li>At home, fa</li> <li>Specify)</li> </ul>	rm, stre	et, factory	, office			28f. Location City or To	(Street an own, State	nd Nur e)	nber or Rura	il Route Num	ber,
	To the Mospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as it	ဦ	29a. Certifier 1 Ce	rtifying Phy	sician: To the	best of m	v knowledge	death	occurred	at the tim	e date a	nd place	and due to the	cause/s	) and i	manner as s	tated	
	Hotely	edical	(Check only 2 Me	dical Exami	ner: On the b	asis of exa ner stated	amination and	d/or inve	estigation,	in my op	pinion, de	ath occur	red at the time	, date and	d place	e, and due to	the cause(s)	)
	withir To th Comp	ž	29b. Signature and title of c	entier	1)				290	. License	number	_		29d. Da	te sigr	ned (Month,	Day, Year)	
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		Ì	30. Name and address of pe						,			,			7	1		
			William Rob					way	Driv	7e, S	salis	bury	, MD 2	1804				
	Stat Registra				2007	ASS	Signature		Local	80								

			For State Registrar	State of Marylar			nt of Heal te of Dea			giene () leg. No.	07	20172
			1. Decedent's Name (First, Middle, Last,	)					2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medic		Jackie Lee Smock			,			6		007	10:11 A M
)	Examin	er	4a. Facility Name (If not institution, give			4b. City	, Town, or Loca	ation of Death			ty of Death	
			Atlantic General			If I leads	Berlin	Inder 24 Hrs.	0 D		ceste	
	Funeral		5. Social Security Number 6. Se	VM 2□F	. iast birtngay) Yrs.	Months		ours Min.	8. Date of Birth (Month, Day	Year)	9. Birth Cot	nplace (State or Foreign untry) T.A
	Director	}	481-62-6008 Usual Residence of Decedent	59		1	J		3/24/1	940		IA
	yland		10a. State 10b. County	10c. Ci	ity, Town or Lo	ocation						10d. Inside City Limits
	Mar B-f st	ţo	MD Worc	ester B	erlin							1 ☐ Yes 2 ☐ No
	or 28	Funeral Director	10e. Street and Number			10f. Zi	p Code			10g. Citizen of	What Cou	untry?
	23a	la	201 Buckingham R	d.			21811			USA		
	er de	nue	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Dece If Yes, spe	edent of Hispan ecify Cuban, Me	ic Origin? (Spe exican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra Bl	ace - Amer ack, White	rican Indian, o, etc.
36	s afte	by F	1 Never Married 2 Married 3 Widowed 4 ☑ Divorced	1 ☐ Yes 2 ☑No If Yes, Give Year or Dates:		1 🗆 Yes	21XNo Sp	ecify:		Spec	ήγ: Whi	te
Ş	within 72 hours after death with the Maryland ene. then "natural", or iteme 23s or 28s-f show he Madigal Examiner must be natified at	edt	15. Decedent's Edu		16a, Dece	dent's Usi	ual Occupation		-	16b, Kind of	Business/I	ndustry
15	in 72 n "ne	plet	(Specify only highest grad	le completed)	(Give	kind of w	ork done during use retired)	most of work	ing			.,
212	d with	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Paint	er			Pain	ting	
Maryland 21215-0036	permit Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be nailified at ODGe.	BeC	17. Father's Name (First, Middle, Last)				18.	Mother's Name	e (First, Middle,	Maiden Suma	ime)	
/lar	uld b Ments rrked	5	Ralph Smock					Dar1	ene DeM	OSS		
an	2 sho and 1		19a. Informant's Name/Relationship (T)		1	•	•		al Route Numbe			
≥	and ealth m 27		Darlene Devos /						Cambrid			
Baltimore,	of H in the		20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐F	Removal from State	Place of Dispo cemetery, crei	osition (Na matory or	ime of other place)		Date	20c. Location	- City or T	Town, State
E	Pag ment ant: ury		4 □ Donation 5 □ Other (Specify)	Ca	Hen			6/7/	and the same of th	Frankf		
3alt	Departiment Important		21. Signature of Funeral Service Licens				nd Address of		ie Burba			Home
	703 # Q		Scill XX	med					erlin, M		1	Approximate
			shock, or heart failure. List only o	lications that caused the dea ne cause on each line.	ith. Do not en	ter the mo	de or dying, su	ch as cardiac (	or respiratory an	rest,		Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a COPU	•							
1	/Medical Examiner			Due to (or as a conse	quence of):							
		ja	Sequentially list conditions,	b. Due to for as a conse	uence of							
	nsit	JE I	Sequentially list conditions, and large many large many large many large cause. Enter Underlying Cause (Disease or injury		77.20							
·	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a conse	quence of):							
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9	ifficat g phy as th	ed									1	
Вох	law requires that the death certific: as been signed by the ettending pl 2 should be detached for use as t	Physician/Med	230. Was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet		Tectonic	pregnancy				ate of deliv	,
	deat	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at time of 9☐ Unknown		Other (s				Ι	Month	Day Year
P.0	at the de by the o	hys	9 🗆 Unknown			1						
	signed b	þ	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	ınderlying	cause given in	Part I.	20			the cause of death?
ord	w requir been si should	ted							1 <b>2</b> 2 Y	es 2□No	3 Pro	obably 4 Unknown
Ö	law las b	nple				_			24a. Was autop	sy	prior to c	topsy findings available completion of cause of
of Vital Records,	ician: The lav certificate has rector, pace 2	Completed							perfor 1 ☐ Yes	2X No	death? 1 ☐ Yes	2□ No
/ita	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				Place of Deat	n (Check only o	ne)		
of	Phye this al dir	P.	1 Yes 2 No  27. Magner of Death	1 Xinpatient 2L	ER/Outpatier 28b. Time o			☐ Nursing Ho	me 5 Resid			cify)
L C	Jing A	ē	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	" м	28c. Injury at Work? 1 ☐ Yes	2 🗆 No	200. Describe ii	ow mijury occi	11100	
Division	Attending ir death. ector: After by the fune	Certification;	<ul> <li>1 Accident investigation</li> <li>3 Suicide 6 Could not be</li> </ul>	28e. Place of Injury - At I	nome farm st			2010	28f. Location /S	Street and Nun	nber or Ru	ral Route Number,
Ď	or A after Dire	erti	4 Homicide determined	building, etc. (Spec	ify)	1001, 10010	19, 011100		City or Tow			
_	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, pace		29a. Certifier 1 Certifying Phy	nwician. To the best of my kn	ciwladge, deat	h occurs	d at the time, di	ata and place.	or id due to the r	rausa(s) and o	nenner as	stated
	• Ho 24 h • Fui letely	edical	(Check only 2 Medical Exami	iner: On the basis of examin	ation and/or in	vestigatio	n, in my opinior	n, death occur	red at the time, o	date and place	and due	to the cause(s)
	To th Withir To th	¥ Me	29b. Signature and title of certifier			2:	c. License nur	nber		29d. Date sign	red (Month	n, Day, Year)
			V/11/1	M.D.			000	64120	>	6/7	1/07	7 ,
			30. Name in address of person who ca	ompleted cause of death (Ite	m 23a) (Type,	Print)	110 D	Parlin	MD	21811		
	BA2		ATIF Zeeshor	ompleted cause of death (Ite 9733 H < Cl 32. Figistrar's Sign	1th wa	yeri	ve o	OI (III)	1.0	~1017		
	Sta		31. Date filed (Month, Day, Year)	32. Pgistrar's Sign	ature	bout						
	Registi	ar	JUNUOZI	JUI TOUR	~ /							

1101: Oct 1/2007 TDD: 1011

481-12-10008 DOB: 03/24/1948

SMOCK, Jackie L.

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2007 June Frederick C. Schierbaum 1:12 P 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 960 West Pulaski Hwy. Ceci1 E1kton 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 ☑ M 2 □ F 84 March 27, 1923 New Jersey 030-20-0637 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Ceci1 Maryland E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 960 West Pulaski Hwy. 21921 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 X Married 1 X Yes 2 ☐ If Yes, Give Year or Dates: 2 🗆 No 1 ☐ Yes 2 ☑ No Specify Specify: 3 Widowed 4 Divorced WWII White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frederick Nicholas Schierbaum Olga Heinrichs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca M. Schierbaum/Wife 960 W. Pulaski Hwy., Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 X Cremation 3 Removal from State 6-11-2007 4 ☐ Donation 5 ☐ Other (Specify) Del Vet Cemetery Bear, Delaware 21. Signature of Funeral Service Licer 22. Name and Address of Facility R. T. Foard and Jones, Inc. 22 West Main Street, Newark, Approximate Interval Between Onset and Death 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final

**Physician** /Medical Examiner

**Physician** 

/Medical

Directo

Funeral

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Completed

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Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural? or them any Injury or other trainment.

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certificate

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I or Attending Physician: after death. Director: After this certifica

within 24 hours a

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Certification: To

Medical

aftending physician

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical

disease or condition resulting in death)

Chronic	Obstrue tre	Puluonas	DIFFER	Onset a
Due to (or as a cons		0		
b. — Due to (or as a cons	equence of).			2.5
cDue to (or as a cons	equence of):			
⊾d				
23c. If yes, outcome pf pres	gnancy		23d. Date of	delivery

IF FEMALE 23b. Was decedent pregnant in the past 12 months? JYes 2□No

9 ☐ Unknown

1 ☐ Live birth 2 ☐ Fetal death 4□Pregnant at time of death

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

Day Month

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 No perfor

3 Probably 4 □Unknown

24a. Was an 26. Place of Death (Check only one

24b.	prior to co	opsy findings available on pletion of cause of
	death?	
	1 ☐ Yes	2 <b>X</b> No
		/ 1

25. Was case referred to medical examiner? 2 No 1 Tes Manner of Death 1 Natural

Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year) 5 ☐ Pending investigation

28b. Time of 28c. Injury at Work? Injury 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 □ ER/Outpatient 3 □ DOA

Other: 4 Nursing Home Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

3 Suicide

4 ☐ Homicide

Scrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

6 Could not be determined

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (imoth)

31. Date filed (Month, State

Registrar's Signature

Year) 200

Registrar

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			1 For State	State	of Marylar			nt of H					007	201	71:
	_		Registrar  1. Decedent's Name (First, Middle	Last)		- 001	unca	C OI L	Jean		2. Date of Dea	th	001	3. Time of	Death
	Physici		Ricky Eugene S								Month June	Day 5	2007	6:15	A M
	/Medic Examin		4a. Facility Name (If not institution		ım <i>ber)</i>		4b. City	, Town, or	Location of	of Death		4c. C	4c. County of Death		
			209 Dutch Driv										Cecil		
	Funeral		,	Months Days Hours Min. (Month, Day, Year) Cour										place (State o	r Foreign
١.	Director		218-68-5885   14M 2   50   Sept. 4, 1956   Virg											ginia	
	how		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside Ci	•
	8a-f	Director		cil		E1kton								1 🗆 Yes	2 X No
	deeth with the Maryland me 23a or 28a-f ehow r must be notified at	Dire	10e. Street and Number				10f. Zi	p Code					en of What Cou	intry?	
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0	r lten	Fun	1 Never Married 2 Marri	Armed F ed 1 ☐ Yes					ecify Yes or No- Rican, etc.)			ck, White, etc.			
oenn-c	tiled within 72 hours after Hygiene. Ither than "netural", or Ite ont, Ite Medical Examina	3 □ Widowed 4 ☑ Divorced   1 □ Yes 2 ☑ No Specify:										5	Specify:	White	9
ה	netu dicel	Completed	15. Decedent (Specify only highes	's Education t grade completed	)	16a. Dece (Give	kind of we		lurina mos	t of worki	ng	16b. Kin	d of Business/Ir	ndustry	
7 7	withir ene. than	dmo	Elementary/Secondary (0-12)	College	(1-4or 5+)		cher	ise retirea,	,			Cmo	aamı Ct	- 0 77 0	
<u> </u>	be filed within 72 hours after deeth with the Marylan Hydione. At Hydione. Ad other than "netural; or lieme 23a or 28a-f ehow event, the Medical Examinar must be notified at	a	17. Father's Name (First, Middle,	Last)		But	cher		18. Mothe	er's Name	(First, Middle,		cery St	.оге	
yland	Aental Aental rked o	ToB	Ira Eugene Sho	rt					Ве	eatri	ice Eliz	abet	h Osbor	ne	
Mar)	2 should be and Mental ie marked of reumatic every		19a. Informant's Name/Relations			19b. Mailir	ng Addres	s (Street a	and Numbe	er or Rura	I Route Numbe	r, City or	Town, State, Zi	p Code)	
e o`	permit. Pages 1 and 2 should by Department of Health and Menta important: if item 27 is marked eny injury or other treumatic evonce.	1	Gregory Short/	Brother	20h I	621 Place of Dispo	100		d, Ri		Sun, M			Cause Cana	
5	ages nt of h :: if ite		20a. Method of Disposition 1X Burial 2 ☐ Cremation		State	cemetery, crei	matory or	other place	1				ation - City or T		
Бант	ortani ortani injury		4 Donation 5 Other (S)		Ho	pewell			s of Facilit		2007	Port	Deposi	t, Mary	land
ä	permit. Depertimpo		I frank	- mi	AH_	R	. T.	Foar	d Fur	ieral	Home,	P.A.	n MD 2	1911	
			23a. Par1. Enter the disease, or shock, or heart failure. List	complications that	caused the dear								11, 110	Approximate Interval Bets	
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	i: The law icete hes t , page 2 s	- 1									perfor 1 ☐ Yes		death?	2⊟-N0	•
A Ital	nding Physicien: The th.: The this certificate funeral director, pages.	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	Manager OF	15D/O-44		Othe			(Check only or		<b>V</b> OV /O	fath	
	g Phy er this eral d	n: To	27. Manner of Death	28a. Date	Inpatient 2 of Injury nth, Day Year)	ER/Outpatier 28b. Time o		28c. Injury Work	4 🗀 Nu		me 5 🗌 Resid 28d. Describe h			hou	se
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<u>"</u>	r Alle ter de irecto	ertific	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ned 286. Plac	e of Injury - At h	ome, farm, str	eet, factor	y, office			28f. Location (S City or Tow		Number or Rui	al Route Num.	ber,
ַ	spital or Atten ours after deat veral Director: filled in by the	0	29a Certifier 1 ertifyin	- Observation - Forth		2000 4 22 - 4 124		ran e		1000	and the second second			400	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	(Check only 2 Medical one)	g Physician: To the Examiner: On the and ma	basis of examina nner stated.	ation and/or in	vestigation	n, in my op	oinion, dea	th occurr	ed at the time, o	date and p	place, and due	to the cause(s	)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier				29	c. License	number			29d. Date	signed (Mohth	Day, Year)	
			Colonia	)	-	~ M	0	Doc	050	646	19	6	16/0	7	
	6		30. Name and address of person	who completed cau	ise of death (Iter	n 23a) (Type,	Print)	10	10	1	- 200	F-1	W.	MES	1921
			31. Date filed (Month, Day, Year)	1501 V	Registrar's Signi	1 Wes	+17	945	JT -0	ouit-	2502	C11	Itan!	411)4	1/0/
	Sta Registr		II IAI	<b>Q</b> 2007	Magice .	B.	grand	2							

		1 - For State Registrar		of Marylar		artment of rtificate o			Reg	ene () ()	7 2	201	75
Phys		Decedent's Name (First, Middle     JOE		IGERS	•			Mo	ite of Death onth		Year	3. Time of D 1 5 4 9	eath M
V a	dical	4a. Facility Name (If not institution,	give street and no	umber)		4b. City, Town	, or Location of		NE	4c. County of	41	1315	
Exan	uner	2933 Brinkle					ple Hi			Princ	ce Ge	eorge	S
Funer			6. Sex 1 <b>X</b> M 2 ☐ F	7. Age (In yrs.	-	If Under 1 Yea Months Day	ar If Under 2	24 Hrs.   8 Da	te of Birth lonth, Day, Y			e (State or	
P.		Usual Residence of Decedent		1.0							1404	1.1.1.1.01	. 1.5 15
show	_	10a. State 10b. County			ty, Town or Lo						100	l, Inside City N∑Yes 2	
Ba-f	Sch	DC		W	ashin					011			
with th	F	10e. Street and Number 1222 Trenton Place, SE 20032								citizen of Wh. ما العاملة			
e 23s	ia.				10 12			in? (Specify V		nited	- American		
re, Maryland 21215-0036 stand 2 should be filed within 72 hours after death with the Maryland stands and 2 should be filed within 72 hours after death with the Maryland Item 27 is merked other then "naturel", or iteme 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Narri 3 Widowed 4 Divorced	Armed F	2 No 19	55 -	Was Decedent of If Yes, specify Control of Image 2 1		, Puerto Rican,	etc.)	Black,	White, etc	0.	
2 hou	Ped	15. Decedent			16a. Dece	dent's Usual Occ	cupation		16	b. Kind of Bus			
715 Maria 2	ple	(Specify only highes Elementary/Secondary (0-12)	1	(1-4or 5+)	(Give	kind of work dor DO NOT use ret	ne during most ired)	of working					
212 d with	Completed	12	College	(1-401 3+)	Waı	cehouse	eman			Priva	te		
e filed other vent, I	BeC	17. Father's Name (First, Middle, I	.ast)				18. Mother	r's Name (First	t, Middle, Ma	iden Sumame,	)		
rian uld be Mental rked o	To E	Babe Sigers						eta Hu					
Maryland 21215-0036 and 2 should be filed within 72 hours aft afth and Mental Hygiene. 27 is marked other then "naturel", or riteumatic event, the Mudical Exami		19a. Informant's Name/Relationsh Lillian Marbu		ers/wi	19b. Maili	ng Address <i>(Stre</i>   222 Tr Vashing	et and Number enton	or or Rural Rout Place DC 20	Number, C	City or Town, S	itate, Zip C	ode)	
S 1 ar		20a. Method of Disposition			Place of Dispo	osition (Name of matory or other p		Date	20	c. Location - C	City or Town	n, State	
Page ent o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		n State		Le Crem		6/18/	07 I	Riverd	ale,	Md.	
Baltimore, permit. Pages 1 a Department of Hes Importent: If Item eny injury or othe	9000	21. Signature of Funeral Service I		os Ds	2	2. Name and Add	dress of Facility	y Hodge	s & I	Edward	s F.	Н.	46
. A.		23a. Pary. Enter the disease, or	complications that	caused the dea					_ <u> </u>		A	opproximate	
Physicia /Medic		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. MET	ASTATIC o (or as a conse		CANCER					Ö	nset and De	∍ath
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	e e	Sequentially list conditions b.											
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ay-tra	xa	that initiated events c.  resulting in death) Last  Due to (or as a consequence of):											
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687 tifficate g phy as the													
Box 6E. death certificate attending phid for use as ti	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy								23d. Date	23d. Date of delivery		
Beath death atte	Ca	in the past 12 months?	4□Pre	birth 2 ☐ Fet gnant at time of		□Ectopic pregna □ Other (specify)				Mont	th D	ay Ye	ear
P.O. that the de by the detached	hys	9 Unknown	9□ Unk	nown									
	by P		ns contributing to	death but not re	sulting in the u	inderlying cause	given in Part I.	. 2	3e. Did toba	cco use contrib	bute to the	cause of de	ath?
ords, requires seen sign hould be								_	1 🗌 Yes	2 □ No 3	3 Probab	oly <b>¥</b> K∏Ur	nknown
() > 10	Completed							2	4a. Was an	24b. W	ere autops	y findings a	vailable
I Rec The lay	Ę								autopsy performe ☐ Yes 2	ad? de	eath?	oletion of ca	use of
Vital sician: T certificat irector, pa	Ö	25. Was case referred to medical	T				26 Place	of Death (Che	975			ZZ IVO	
	0 8	examiner? _1 ☐ Yes _2 🔀 No	Hospital:	Inpatient 2	TER/Outpatie	nt 3 DOA	Othor	rsing Home 5			r (Specify)		
	<u> </u>	Tan III To tan III		e of Injury onth, Day Year)	28b. Time o		njury at Work?			injury occurre			
ion C nding P th.: After i	흹	1 ♠ Natural 5 ☐ Pendin 2 ☐ Accident investig	9	ontn, Day rear)	Injury		work? □Yes 2□I	No					
Division or Attending after death. Director: After	Certification:	3 Suicide 6 Could r 4 Homicide determ	280. Pla						ocation (Stre lity or Town,	et and Numbe State)	r or Rural F	Route Numb	ΘΓ,
Hospita 24 hours Funeral tely filled	edical C		g Physician: To the Examiner: On the and ma										
To the within 2 To the comple	₹ S	29b. Signature and title certifie				29c. Lic	ense number		290	d. Date signed	(Month, Da	ay, Year)	
F \$ F ō		1 / Ko	1 h 111	X		MD	# 31139		JU	NE 13,	2007		
- 1 1	1	30. Name and address of person	who completed ca	use of death (Ite	m 23a) (Tvne	. Print)							
4	( )	ROBIN W. PECK,					NILI LIAC	HTMCTO	א דור י	በ <i>ሉንን ነፋ</i> ና	RR		
14 0	State	31. Date filed (Month, Day, Year)	32	Registrar's Sign	ature		TALL 6 LAST	MINGIO	ک_کالاوی	<u> </u>			
	strar	JUN 2 1	2007	Registrar's Sign	S GOO	de s							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 3. Time of Death Day Physician DAVID **LEROY** SMEAK, SR. 16, 2007 11:15 A M June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 75 York Street Carroll County Taneytown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | May 21, Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1X M 2□F 218-24-1650 76 Yrs. Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1 XYes 2 No Maryland Carroll County Taneytown Director 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 75 York Street 21787 United States Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 □ Yes 2 □ No Specify: 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: white 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
firefighter Elementary/Secondary (0-12) College (1-4or 5+) emergency services 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harvey Noah Smeak Madeline Koontz ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen E. Smeak / wife 75 York Street Taneytown, Maryland 21787 20b. Place of Disposition (Name of cemetery, crematory or other place) e 20 2007 20a. Method of Disposition 20c. Location - City or Town, State June 1 Description 3 □ Removal from State Keymar, Maryland Keysville Union Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Skiles Funeral Home 136 East Baltimore Street Taneytown, Md. 21787 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** 48915 resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease o, injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-trans Due to (or as a consequence of): physician Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No c te has een siç page 2 should b 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed?

1 Yes 2 X No certificate After this certification funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

requires that the death certificate be executed P.O. Box 68760. Records, Division or Vital or Attending Physician: To the Hospital

Baltimore, Maryland 21215-0036

State

Registrar

DHMH 17 Rev 1/2001

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bathmore

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date şigned (Month, Day, Year)

			State of Maryland / Dep	artment of Health and I		2007	20177					
			1. Decedent's Name (First, Middle, Last)  2. Date of Death									
	Physicia		CLIFFORD SYLVESTER SWEENEY SP TUNE 14 2007									
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death	1-1-					
1			SO.MARYLAND HOSP.CENTER	CLINTON		PRINCE G	EORGE					
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth	te of Birth 9. Birthplace (State or Footh, Day, Year)						
	Director		213-22-1080 TW 2 F 81		11-15-	1925 MD.						
	and t		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits					
	Mary -f sho fied a	ţŏ	MD. PRINCE GEORGES	CLINTON			Yes 2□No					
	r 28a	irec	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cou	ntry?					
	th with	Funeral Director	9211 STUART LANE	.S.A.								
	ems er mu	iner	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,						
36	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No NAVY	1 ☐ Yes 2 ☐ No Specity:		Specify: WH	TTE					
Ö	hours tural'	g p	3 ☐ Widowed 4 ☐ Divorced Year or Dates: WWII ☐ 15. Decedent's Education ☐ 16a. Dec	edent's Usual Occupation	16	b. Kind of Business/In						
<u>1</u>	in 72 "na" na ledic	Completed	(Specify only highest grade completed) (Giv	e kind of work done during most of wor DO NOT use retired)	rking	b. Paris of Basinessyni	io con y					
212	with jiene r thai	mo	Elementary/Secondary (0-12) College (1-4or 5+) THOT	OUGHBREED HORS	E TRAINE	R SELF	EMPLOY					
ğ	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nar	ne (First, Middle, Ma.	iden Surname)						
/lai	Menta Menta arked atic e	70	ROBERT SWEENEY	EDNA	IRENE W	ALKER						
Baltimore, Maryland 21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			ing Address (Street and Number or Ro	,		o Code)					
<i>a</i> `	l end lealth m 27 her tu			TH STREET LOTH		20711 c. Location - City or T	aum State					
lor	iges or of h		1 Desural 2 Ocemation 3 Demoval from State	position (Name of ematory or other place)								
蕇	it. Pa intmer intant: injuny			ANS CEMETERY 6 -	19-07 C	HELTENHA	M,MD.					
Ba	permi Depa Impo any Ir		21. Signature of Ferneral Service Licensee MOO 4 79	RAYMOND FUNERAL	L SERVIC	E,P.A.						
	100		23a. Part1. Enter the disease, or complications that caused the death. Do not e	LA PLATA, MD. 2 of the mode of dying, such as cardial	0 6 4 6 c or respiratory arrest	t,	Approximate Interval Between					
	Physician	0.1	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  ATheras Clear hi	e Cardiovas le	0.5		Onset and Death					
	/Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):	ne	25.							
	Examiner		Sequentially list conditions b.		3dan-							
_	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		0							
W	be execute ician and burial-trans	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):									
8760,	ate be executed ohysician and the burial-transit		Substitution and a solid equation of the									
687	ficate physics the	edical	d									
Box	eath certific attending p	N	IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of deliv	/ery					
	death e atte	icia	in the past 12 months?  1 Ves 2 No 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year					
Ö.	at the by th tache	hys	9 ☐ Unknown 9 ☐ Unknown				1.7					
Division or Vital Records, P.O.	or Attending Physician: The law requires that the death certific feeth.  Director: After this certificate has been signed by the attending p in by the funeral director, page 2 should be detached for use as	by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to	41					
ord	requii	ted			⊺∐ fes	2 No 3 Pro	bably 4QUnknown					
ec	law asb	nple.			24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of					
<u>=</u>	: The cate ha	Completed			performe 1□ Yes 2		2 No					
VIII:	ung Physician: The Affer this certificate funeral director, pag	B	25. Was case referred to medical examiner?	Othor:	ath (Check only one)							
ō	Phys r this ral dir	- T	1 Yes 2 No rospital 1 Inpatient 2 ER/Outpati 27. Manner of Death 28a. Date of Injury 28b. Time	ent 3 DOA 4 Nursing P	dome 5 ☐ Residena 28d. Describe how	ce 6 Other (Spec	ify)					
on	dlng I th. : After funer	tion	1,⊠Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	of 28c. Injury at Work?  M 1 Yes 2 No								
Visi	l or Attendatter death	ifica	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, suilding, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	et and Number or Rui	ral Route Number,					
ā	safter safter al Dire	Certification:	uniding, etc. ( <i>Specify</i> )		Only of Young	Sialej						
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only (Ch									
	thin 2 the I	Medical	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29r	d. Date signed (Month	Day, Year)					
	T w S		29b. Signature and the of certainer	045365	230	06-14-						
	aul		20. Alama and address of person who completed agues of death (Item 23a) (Typ	- Print\		*						
	341		Michael Sidenous, m. P. 1170/ /inings.	ton RI HIPLAT	washigha	10207	44					
	Sta	ate	31. Date filed (Month, Day, Year) 32 Registrar's Signature									
	Regist	rar	111N 2 1 2007 As As									

1.	-	For State Registrer				
1.	D	ecedent's l	Name	(First,	Middle,	Last)

Certificate of Death

3. Time of Death

Physician	
/Medical	
Examiner	

2. Date of Death

Month

June

4

Day 2007 8:24 P M

**Funeral** 

Director

Re Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Itam 27 is marked other than "naturat", or Itams 23a or 28e-1 show any injury or other treumatic event, tra Medical Examinar must be nutitied at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

isi Division of Vital Records, P.O. Box 68760,

1	to the hospitel of Attending Physician. The law requires that the death certificate be execut
1	within 24 hours arter death.
_	To the Funeral Director: Atter this certificate has been signed by the attending physician and
	completely filled in by the funeral director, page 2 should be detached for use as the burial-trar

Rosa Etta	Hicks Ta	aylor			June	<b>4</b> , Day	200 <sup>7</sup> ar	8:24 P
4a. Facility Name (If not institution, give			4b. City, Town, o			4c. (	County of Deat	th
Gladys Spelman		Center		verly			P.G.	
5. Social Security Number 6. Sec. 1579-54-4206	7. Age (In 80	yrs. last birthday) Yrs.	Months Days	If Under 2 Hours	8. Date of (Month) 10-	Birth Day, Year) <b>9-26</b>	Co	thplace (State or Forei buntry) • C -
Usual Residence of Decedent								
MD. 10b. County P.G		c. City, Town or Lo Hyatt:	sville					10d. Inside City Limit
10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Co	ountry?
3559- 55th Ave	enue #3		2078	4		U	.S.A.	
11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13. V	Was Decedent of H	ispanic Orig	gin? (Specify Yes or , Puerto Rican, etc.	No- 1	4. Race - Ame Black, Whit	
1 Never Married 2 Married	1 ☐ Yes 2X No If Yes, Give		1 ☐ Yes XXNo	Specify:	, , , , , , , , , , , , , , , , , , , ,		Specify: B	
3 ₩ Widowed 4 Divorced	Year or Dates:		103 22310	Opeony.				
15. Decedent's Edu (Specify only highest grade	cation e com <i>pleted)</i>	16a. Deced	dent's Usual Occup kind of work done DO NOT use retired	ation during most	of working	16b. Kin	d of Business	
Elementary/Secondary (0-12)	College (1-4or 5+)					Mon	+ C+5	Schoo Public
12th		Mai	nt. Wor					y Fubite
17. Father's Name (First, Middle, Last)					r's Name (First, Mid		Su <i>m</i> am <i>e)</i>	
Garfield Hi					allie T			
19a. Informant's Name/Relationship (Ty			ng Address (Street	and Numbe	r or Rural Route Nu	m <i>ber, City</i> or	Town, State, 2	Zip Code)
Rosalind Burne				h Ave		attsv	ille,	Md. 2078
20a. Method of Disposition  ↑ Structure   2 □ Cremation   3 □ F	1	<ol> <li>Place of Dispo cemetery, cren</li> </ol>	sition (Name of natory or other place	(a)	Date	20c. Loc	cation - City or	Town, State
4 □ Donation 5 □ Other (Specify)		Harmony	Mem Pa	rk   6	5/11/07	Lan	dover	, Md.
21. Signature Funeral Service Licens	Hacket	1 22	Name and Addre Hacket	ss of Facilit	uneral	Chape	l, Ind	c.
23a. Pay11. Enter the disease, or compl	inations that caused the	doub Do not ont	814 Up	shur	Street,	N.W.		Approximate
shock, or heart failure. List only or	ne cause on each line.	death. Do not ent	er the mode of dyli	ig, sucii as	cardiac or respirato	y arrest,		Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	Pneumor	nia						3 weeks
resulting in death)	Due to (or as a co							
Sequentially list conditions,	D	atory F	ailure					8 months
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequence of):						
that initiated events resulting in death) Last	3.							
	Due to (or as a co	nsequence or):						
	d						_	
IF FEMALE:								
23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pr □ Live birth 2	Fetal death 3	Ectopic pregnancy	,		2	3d. Date of de Month	livery Day Year
1 ☐ Yes 2 🙀 No	4□Pregnant at time 9□Unknown	of death 5	Other (specify)			_	MOHIT	Day Feat
9 Unknown								
Part II. Other significant conditions conditions  Diabetes Mel.	-	ot resulting in the u	nderlying cause giv	en in Part J.				o the cause of death?
Diabetes Mei	IILUS				1	☐ Yes 2L	JNo 3∏Pi	robably 4 Munknov
Cerebrovascu	lar Accide	ent				Vas an	24b. Were at	utopsy findings availat completion of cause of
					10 Y	utopsy erformed? es 2 No	death?	
25. Was case referred to medical				26 Place	of Death (Check o		10.16	2 140
examiner?	Hospital:	2 ER/Outpatien	nt 3 DOA Oth		rsing Home 5 F		□Other /Soc	ecifu)
27, Manner of Death 1X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time of	f 28c. Injur	y at k?	28d. Descr	be how injury		w.y/
2 Accident investigation 3 Suicide 6 Could not be				Yes 2 🗆				
4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, str specify)	eet, factory, office			on (Street and Town, State)		ural Floute Number,
(Check only 2 Medical Exami	sicien: To the best of mi	imination and∕or in	h occurred at the till vestigation, in my o	me, date an pinion, dea	d place, and due to th occurred at the ti	the cause(s) me, date and	and manner as place, and due	s stated. e to the cause(s)
one)	and manner stated.	-//-						
29b. Signature and title of gertifier	Mun	May -	29c. Licens	6273		Zad. Date	signed (Moni	yay, rear)

DHMH 17 Rev 1/2001

State Registrar

3001 Hospital Dr. Cheverly, Md.

20785

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Revathy Murphy,

DHMH 17 Rev 1/2001

Registrar

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

•		1- For State Registrar	o manyiana	Cert	tificate of	Death			g.cc R	eg. No.	JUIC	910
Physici		Decedent's Name (First, Middle, Language)	ast)						2. Date of Dea	th Day Year	3. Time of D	
edical Exami	iner	Kelsy Lynn Thomas June 11, 20								2007	1615 h	rs
		4a. Facility Name (if not institution, g University Hospital	ive street and number)	)	4	b. City, Tow Baltimo		tion of Death		4c. County of	Death	
Funcial			Sex 7. Aq	e (In vrs. Ia	ist birthday)	If Under 1		Under 24Hrs.	8 Date of Bir	N/A	Birthplace (State	e or
Funeral Director		219-25-2519	M 2XF	ic (iii yis. id	20 Yrs.	Months		Hours Min.	1	10,1987	Foreign Country)Mar	
any	,	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Locati	on					10d. Inside	City Limits
* .	ا ا	Maryland Washi	ngton	Fu	nkstown	1					1 Yes	2 X No
Aaryland 28a-f show 1 at once,	Director	10e. Street and Number	8			10f. Zip Co	ode		1	0g. Citizen of Wha	at Country?	
vith the Maryland s 23a or 28a-f show e notified at once,	Dire	102 West Green	Street			21	734			USA		
with ms 23	uneral	11. Marital Status	12. Was Decedent						ecify Yes or No		American Indian, B	3lack,
or ite	Fun	1 X Never Married 2 Marri	1 Yes 2	X No				xican, Puerto I	Rican, etc.)	White,		
s after ral", niner	b l		ed If Yes, Give Year or Dates:		16a. Deceden	Yes 2 X			-11-1	Specify: V		
2 hour "natu	ted	15. Decedent's Education (Specify Elementary/Secondary (0-12)	College (1-4 or					NOT use retin		16b. Kind of bus	iness/industry	
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", e event, the Medical Examiner	Completed	12		,	N/A					N/A		
5-0( led wi tygier other	၂၀	17. Father's Name (First, Middle, La	st)				18. <b>M</b>	other's Name	(First, Middle,	Maiden Surname)		
121 I be fi ental I arked	Be	Stephen G. Tho								e Thomas		
D 21; should be and Men	2	19a. Informant's Name/Relationship			1		`			mber, City or Town		0
re, MD s 1 and 2 sho of Health and If item 27 is		Stephen G. Tho 20a. Method of Disposition	mas/Father	20b. F	Place of Dispos				Date		Md. 2174 City or Town, State	
		1 Burial 2 X Cremation	3 Removal from St	late	crematory or oth			6/1	E /2007	C 4 + h 1	Man	1
Baltimo Department Importants		4 Donation 5 Other Spec 21. Signature of Funeral Service Lic		Sm	ithsbur	-		-		n Funeral	ourg, Mar	yrand
Balti permit. Departr Import injury		5 Mente 9	Sums								town Md 2	1742
Physician		23a. Part I. Enter the disease, or confailure. List only one cause on	mplications, har caused	the death.							rt Approxima	ate Interval Onset and
- Medical Examiner		Immediate Cause (Final disease	a. Multiple Injuries	3								eath
		or condition resulting in death)	Due to (or as a cons	sequence of	f):							
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	sequence of	f):							
	Examine	Cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in Reath.) Last  Due to (or as a consequence of):										
ansit a styl	X	events resulting in death) Last	d.	sequence or	r):							
760, kinate be executed physician and the burial - transit	Medical	UNPENDED	AMENDED		,							
760, ficate be g physici the burit	ĕ	IF FEMALE:	23c. If yes, outco	23c. If yes, outcome of pregnancy 23d. Date of							delivery	
68/ certifi nding se as t	/sician/	past 12 months?									Day	Year
Box 68: death certif	ysic	1 ✓ Yes 2 No 9 Unkno			5 Ot	her (Specify	<i>y</i> )					
of Vital Records, P.O. Box 68' ing Physician: The law requires that the death certifical After this certificate has been signed by the attending tuneral director, page 2 should be detached for use as:	/ Phy	Part II. Other significant condition	is contributing to dea	th but not re	esulting in the u	underlying ca	ause given	in Part I.			bute to the cause of	
ires th signe	d by								1Ye	s 2 ✔ No 3	Probably 4	Unknown
ords w requ	Completed				***				24a. Was auto	psy p	Vere autopsy finding rior to completion of	
Reco	[										eath? ✓ Yes 2	No
al Finn:	မ္က	25. Was case referred to medical examiner?				26		Death (Check o	only one)			
Vit hysic r this c	10 B	1 ✓ Yes 2 No	Hospital: 1 / Inpati		ER/Outpatient				g Home 5	Residence 6	Other:	
C		27. Manner of Death  1 Natural 5 Pending	28a. Date of Inj (Month, Day, Jun 9, 2007	jury Year)	28b. Time of I 0157 hrs		c. Injury at			how injury occurre auto collision		
Siol Attender: death	l i	Natural 5 Pending Investigation Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rur.								or Or Pural Pouto No	umbor City	
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the safer death.  The law for the this certificate has been signed by the funeral director, page 2 should be detaalled in by the funeral director, page 2 should be detaal	Certification:	3 Sulcide 6 Could r	not be			er, ractory, o	ince bandi		or Town,	State)	ousetown Road, I	
The second secon												
o the lithin 2 o the l	edical		ner:On the basis of exa	amination a								
- 3 - 3	§ Be	29b. Signature and title of certifier	and marino, states			29c. L	License nu	mber		29d. Date signe	ed (Month, Day, Yea	ar)
		and ?	_			(	O.C.M.E			June 13, 20	007	
_		30. Name and address of person wi	· · · · · · · · · · · · · · · · · · ·		•							
J.			tant Medical Exa		111 Penn S	street, Ba	iltimbre,	MD 21201	l			
S Regis	state	15 7A 1 C) 7 CC	32. Registr	ar's Signatu	ле Дода	25						

			1 - State Registrar			Cei	tificate of	Death		Reg. No.	jU/	2018
	Physici		Decedent's Name (First, Middle,  Rose	Last)	iams				2. Date of D Month June 4	Day	Year	3. Time of Death 5:16 a M
	/Medic Examir		4a. Facility Name (If not institution,				4b. City, Town,	or Location of D			nty of Deat	
			1241 Cavendi	sh Drive			Si1	ver Sprin	ng		Montgo	omery
	Funeral		5. Social Security Number		Age (In yrs. I		if Under 1 Year Months Days			irth Day, Year)	9. Birt'	hplace (State or Foreign
	Director		190-38-6522	1□M 2 <b>⊠</b> F	60	Yrs.	Working	riodis	June 7			nsylvania
	and w	]	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	Aaryii f sho ed at	ē	Maryland Montgo	merv	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,		Spring				1 ☐ Yes 2 k No
	the N 28a-l	Directo	10e. Street and Number				10f. Zip Code	Dpi 1116		10g. Citizen	of Mhot Co	
	with ga or	٥	1241 Cavendi	ah Dwive				20905			U.S.A.	,
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  is marked other than "natural", or Items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.	S. 13. \			? (Specify Yes or N			rican Indian,
0	or Iter	Ē	1 ☐ Never Married 2 ☐ Marrie			'	f Yes, specify Cul	oan, Mexican, P	uèrto Rican, etc.)		Black, White	
2	ours a ral", o Exan	b	3 ☐ Widowed 4 🖾 Divorced	If Yes, Give Year or Date	es:		I∐Yes 2 <b>X</b> No	Specify:		Spe	cify: Af	rican-America
ה ה	72 ho natui lical	Completed	15. Decedent's (Specify only highest	s Education	- V	16a. Deced	lent's Usual Occu	pation	working	16b. Kind of	Business/	Industry
7	thin he.	힐	Elementary/Secondary (0-12)	College (1-4	or 5+)	life. L	kind of work done OO NOT use retire	ed)	working			
7	ed wi	ပ္ပြ		5+			Tumor Regi	strar			ncolog	у
2	be fill tai H d oth even	Be	17. Father's Name (First, Middle, L	.ast)				18. Mother's	Name (First, Middi	e, Maiden Surr	iame)	
<u>x</u>	ould I Men arke	2	William Thom			1		Ros	se Marie Th	ompson		
Ö	2 sh and is m raum		19a. Informant's Name/Relationshi	ip (Type. Print)		19b. Mailin	g Address (Stree	t and Number o	r Rural Route Num	ber, City or Tov	vn, State, Ž	Iip Code)
≤ 15	and lealth m 27 her ti		Sabrina Williams	- Daughter	les e	<u> </u>			ele, German	, <u> </u>	20874	
5	ges 1 If of H If ite		20a. Method of Disposition 1   Burjal 2   Oremation	3 Removal from Str	ate 20b. P	emetery, crer	sition (Name of natory or other pla	ace)	Date	20c. Locatio	n - City or	Town, State
	tmentment:		4 □ Donation 5 □ Other (8p	ecity			emorial Pa		/7/2007	Monroev	ille,	Pennsylvania
0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any lulry or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service L	icersee			. Name and Addr ines-Rinal		al Home, In	c.		
	0.0260		Jaky	/ h. / fr	u	1	1800 New E	lampshire	Avenue, Si	lver Spri	ng, Ma	ryland 20904
			23a. Part1. Enter the disease of shock, or heart failure. List	omplications that cau nly one cause on eac	sed the death h line.	Do not ente	er the mode of dy	ing, such as car	diac or respiratory	arrest,		Approximate Interval Between Onset and Death
ĵ,	Physician		Immediate Cause (Final disease or condition resulting in death)	Gliob	lastoma	Multifo	rm					Oriset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequ	uence of):						
		_	Sequentially list conditions, if any, leading to immediate	b								
	ied isit	je	cause. Enter Underlying	Due to (or	as a consequ	lence of):						
	xecut and Il-trar	Examiner	that initiated events resulting in death) Last	c	as a consequ	ience of):						
5	be e ician buria					201.00 01/1.						
000	certificate be executed rding physician and se as the burial-transit	Medical		d					***			
3	certii nding se a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me pf pregna	ncy				224	Data of dol	lyon
วั	atter for u	Physician	in the past 12 months? 1 ☐ Yes 2 ☒ No	1 ☐Live birtl	h 2 ☐ Fetal nt at time of de	death 3	Ectopic pregnant Other (specify)	су			Date of deli Month	Day Year
į	the c y the ichec	ıysi	9 ☐ Unknown	9□Unknow			(// -					
٦,	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use		Part II. Other significant condition	ns contributing to deat	h but not resu	ulting in the ur	nderlying cause gi	ven in Part I.	23e. Did	tobacco use co	ontribute to	the cause of death?
3	quires n sign ald be	d by							1 🗆	]Yes 2█ No	3 ☐ Pr	obably 4 Unknown
3	w rec	lete						_	24a. Wa	s an 24	h Ware au	topsy findings available
ב	he la e has	Completed							— aut	opsy formed?	prior to death?	completion of cause of
2	ifficat		25. Was case referred to medical					OC Plans of	1 Yes		1 🗆 Yes	2□No
>	rsicia s cert	o Be	examiner? 1 ☐ Yes 2 🔼 No	Hospital: 1 ☐ Inp	sationt 2 🗆	ER/Outpatien	t 3 DOA Ot	her:	Death (Check only			
5	3 Phy er this		27. Manner of Death	28a. Date of	Injury	28b. Time of	1 JU DON	4 LI Nursir	ng Home 5 X Re	e how injury occ		zify)
5	th.: Afte	ţi	1 Natural 5 Pending 2 Accident investiga		Day Year)	Injury		ork? ]Yes 2∐No		, ,		
2	Atter r dea ector by the	ifica	3 ☐ Suicide 6 ☐ Could no	ned 28e. Place of	injury - At ho	me, farm, str	eet, factory, office				mber or Ru	ural Route Number,
5	al or s after I Dir	Certification:	4 Homicide determin	building	, etc. (Specify	1)			City or T	own, State)		
	splta hours inera y fille		29a. Certifier 1 Certifying	Physician: To the be	est of my know	wledge, death	occurred at the t	ime, date and p	lace, and due to th	e cause(s) and	manner as	stated.
	n 24 n 24 ne Fu	Medical	(Check only 2 Medical E	xaminer: On the basi and manner	is of examination of state of the state of t	tion and/or in	estigation, in my	opinion, death	occurred at the time	e, date and plac	e, and due	to the cause(s)
	vithii To th	ž	29b. Signature and life of certifier	100	1/10		29c. Licen	se number		29d. Date sig	ned (Monti	h, Day, Year)
)	10		Hele	PRO	10	N	MD	7600		June	e 6, 20	007
	6		30. Name and address of person w	vh completed cause	of death (Item							
			Dr. Cohen, 3800 I				,					
72	Sta		31. Date filed (Month, Day, Year)	Property 197	strar's Signa							
	Registr	ar	JUN ()	7 2007	ALINO .	M. K	backs					
DHI	MH 17 Rev 1/2	001										

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1- State Amend #27,28a-f, perME,g870, 8/3/07Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) June 200 7ai **Physician** 4:35 P M Mabel Rosita Widdows /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Washington County Hospital Hagerstown If Under 1 Year | tf Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Feb 6 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months 1 □ M 2 F 93 Maryland 1914 220-18-0695 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Hygiene. other than "natural", or Itema 23a or 28a-f ahow ant, the Medical Examinar must be notified at 1 Yes 2 No Hagerstown Maryland Washington Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21742 U.S.A. 219 Calvert Terrace Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No tf Yes, Give Year or Dates: Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married White 1□Yes 2ŽNo Baltimore, Maryland 21215-0036 Specify. Specify. δ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygient Important: If item 27 ia marked other the any injury or other traumatic avant, Inc. 2006. City Government Clerical 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lydia Slick Harry B. Wolfinger ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 257 Potomac Heights Hagerstown Maryland 21742 Norris Diefenderfer - friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Maryland 6-12-07 Smithsburg Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 7 27,0 **Physician** /Medical Due to (or as a consequence of) Examiner wertestort colof Sequentially list conditions, if any, loading to immoduate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner RTIFICATION APPROVED BY MEDICAL EXAMINER attending physicien and for use as the burial-transit or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy bouth 2 1 No 64 eminto 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Diffaturai 1 ☐ Yes 2 🛣 No subject fell 05/30/2007 within 24 hours after death. To the Funeral Director: A 2 XAccident 4:15 pm 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Nursing Home 14014 Moush Pike Hagerstown, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Datte MS JUME 8, 2007 018019 E CODI HO TI MO

SH-7

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)
JUN 1 2 2007

VASANT DATTA

3 40 M/4 S

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Spell

		1	For State Registrar	State of I		d / Depa		of He	ealth a		ental Hyg	iene g. No.	007	20	83
	Physicia		1. Decedent's Name (First, Middle, La Peggy Irene Wolf								2. Date of Deat Month	h Day 9	2007	3. Time of 9:45	Death A M
)	/Medic Examin	al -	4a. Fecility Name (If not institution, given Beverly Healthca	e street and numb			4b. City, Hage		Location o	of Death	June_	4c. Co	unty of Death Vashing	d	
Ī	Funeral Director		5. Social Security Number 218-30-7603		Age (In yrs. I 75	ast birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birth Month, Day, 07/09/1	931	9. Birthp Cour	olace (State on htry) MD	r Foreign
	yland	-	Usual Residence of Decedent  10a. State 10b. County			y, Town or Lo							1	l 0d. Inside Cil	
	the Mar	ector	MD Washing	gton	Н	agerst		Code		_	1	0g. Citizer	n of What Cou		2010
	23a or	al Dir	11 E. Washington	n Street,	Apt.			1740					US		
36	be filed within 72 hours after death with the Maryland tal Hyglene dother than "neturel", or items 23a or 28a-f ehow event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Deceded Armed Force 1 Test 2 If Yes, Give Year or Date	ss? █∑No		Was Deced f Yes, spec 1 ☐ Yes		spanic Ori n, Mexicar Specify:	gin? (Spe 1, Puerto	ecify Yes or No- Rican, etc.)		Race - Americ Black, White, pecify: Wh		
Maryland 21215-0036	within 72 ho ane. than "netur	Completed	15. Decedent's E (Specify only highest g. Elementary/Secondary (0-12)		or 5+)		dent's Usua kind of wor DO NOT us Secre	k done d e retired)	u <i>ri</i> ng mos	t of work	ing	16b. Kind	of Business/Ir		
land z	g ia b	To Be Co	17. Father's Name (First, Middle, Las Charles Downs We			1			I	da V	e (First, Middle, irginia	Mark	S		
Mary	s 1 and 2 should I if Health and Meni item 27 ie marke other traumatic		19a. Informant's Name/Relationship Katherine V. Wi								al Route Number , Hagers				
Baltimore, I	Pages 1 amment of Heali ant: if item 2 ury or other		20a. Method of Disposition  1 ⊠ Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spec	☐Removal from St	ate Res	Place of Dispo cemetery, cree	sition (Nar	ne of ther place	9)	[	Date 2/3007	20c. Loca	tion - City or T	own, State	
Baltii	permit. Pages Department of Important: If it eny injury or gace.		21. Signature of Funeral Service Lice	ense	2	30	2. Name an	d Addres	s of Facili	y Ge Stre	rald N. et, Hage	Minn ersto	ich Fur	neral H	Tome
760,	Physician and Asician and Asic	cal Examiner	23a. Part1. Enter the disease, or co- shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (o		juence of):					,	esi,		Approximation Interval Bet Onset and 3 FT 00	ween
P.O. Box 687	Attending Physicien: The law requires that the death certificate reasth. sctor: After this certificate has been signed by the attending physic the funeral director, page 2 should be detached for use as the	by Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Feta nt at time of c	aideath 3[	⊒Ectopic p ⊒ Other (s)					23	d. Date of delin		Year
	uires that t signed by Id be deta		Part II. Other significant conditions	contributing to dea	th but not res	sulting in the u	underlying	ause give	en in Part	1.		obacco use 'es 2 🗆	contribute to	V	death?  Unknown
Division of Vital Records,	hysicien: The law requir his certificete hes been si il director, page 2 should I	Completed					· · · · · · · · · · · · · · · · · · ·					an esy rmed? 20 No	24b. Were au prior to d death? 1 ☐ Yes	topsy findings ompletion of a 200 No	available cause of
Vita	ician: sertifica ector, I	Be	25. Was case referred to medical examiner?	Hospital:				Oth	1		th (Check only o		70th-s (6		
on of	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this: completely filled in by the funeral dir	tlon: To	1 ☐ Yes 2 € No  27. Manner of Death  Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date o		28b. Time of Injury		28c. Injun Wor	y at		ome 5 Residence Residence Page 1			ny)	
Divisi	al or Attens attended in Director	Certification:	3 Suicide 6 Could not determine	289. Place	of Injury - At h g, etc. (Speci	nome, farm, si ify)	treet, factor	y, office			28f. Location (S City or Tou		Number or Ru	rai Route Nur	nber,
	te Hospital or 124 hours afte te Funeral Dir bletely filled in	edical	29a. Certifier Certifying (Check only one)	Physician: To the aminer: On the ba and mann	sis of examin er stated.	ation and/or in	nvestigation	n, in my o	pinion, de	ath occu	rred at the time,	date and p	lace, and due	to the cause(	
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier	9/84	an		29	c. Licens	836	5 5		29d. Date	signed (Mont)	h, Dey, Year)	
ď	4-3		30. Name and address of person w	no completed cause	of death (Ite	36 8	, Print)	le	Str.	ceil-	Hag	ersp	ru M	10 21	740
	St Regist	ate rar	31. Date filed (Month, Day, Year)  JUN 12	2007	lgistrar's Sign	J. A	parke	/							

			For State Registrar	State of	Marylan			nt of Health te of Deat		•	giene Reg. No.	2007	20184
	Physicia	an	1. Decedent's Name (First, Middle, La							2. Date of De Month	Dav	2007	3. Time of Death
	/Medic	al	Jer: 4a. Facility Name (If not institution, give		Lee		Wise	. Town, or Locatio	on of Doath	June	6,	2007 County of Death	11:58A M
,	Examin	er	Shady Grove Ad			al	,	ckville	on Death			Montgon	
Ť	Funeral		Social Security Number     6. 8		Age (In yrs.		If Unde		der 24 Hrs.	8. Date of Bir (Month, Da	th v. Year)	9. Birth	place (State or Foreign
ı.	Director		101 21 0330	ATM 2UF	77	Yrs.	Months	Days House	]	March 1	6, 19	930 Peni	nsylvania
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	Mary a-f sh ified a	tor	Maryland Montgom	ery	Ge	rmanto	wn						1 □ Yes 2 No
	ith the	Director	10e. Street and Number					p Code			10g. Citiz	zen of What Co	untry?
	sath w	ral	18504 Kingshill			0 140		20874	0::-0:0			U.S.A.	ion Indian
	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status  1 □ Never Married 2 Married	12. Was Decede Armed Force 14 Yes 2	es?			edent of Hispanic ( ecify Cuban, Mexi-	ican, Puerto	ecity Yes of No Rican, etc.)	)-	Black, White	
	ours at ral", or Exam	þ	3 ☐ Widowed 4 ☐ Divorced	If Voc Civo	es: Kore	an	1 ☐ Yes	2X No Speci	ify:			Specify: W	nite
	72 hc 'natur dical	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Deced	dent's Us kind of w	ual Occupation ork done during m use retired)	nost of work	ring	16b. Kir	nd of Business/I	ndustry
1	within ene. than '	Jd mo	Elementary/Secondary (0-12)	College (1-4	lor 5+)			use retired) Operator				Tile Co	npany
2	filed Hygi other ent, tl	Be Cc	17. Father's Name (First, Middle, Last	<u> </u>		I		18. Mo	other's Name	e (First, Middle	, Maiden	Surname)	
3	uld be Aental rked ( tic ev	To B	(Unknown)						Beat	rice W	ise		
3	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Breatment of Health and Mental Hygiene. Immortant: If term 27 is marked other than "natural; or Items 28a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	ľ	19a. Informant's Name/Relationship Mary Lou Wise - W			1	-	ss (Street and Nur					
5	1 and Health Sm 27 ther tr		20a. Method of Disposition		20h £				,	, Germa		cation - City or	Land 20874
5	ages ant of l		1 ☐ Burial 2 ☐ Cremation 3 [		ate i	Place of Dispo cemetery, crei		otherplace) Cremator:	1				Virginia
	mit. P partme oortan finjur		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		. 3			and Address of Fa					
ĭ	Depar Import any fr		Forest L.	Mill	exm		2640	swortn-w: 1 Ridge 1	riita Road,	ms P.A. _ Damas	, fui cus,	neral но Marvlaı	ome nd 20872
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cau	used the deat ch line.							•	Approximate Interval Between Onset and Death
F	Physician		Immediate Cause (Final disease or condition resulting in death)			on Pne	umon	ia					3 hours
	/Medical Examiner		Toolaining in dodain,		ras a conseq	uence of): ic Colo	on C	naor					Months
ļ,		Je.	Sequentially list conditions, if any, leading to in mediate					HOHEHS					
	ecuted .nd transit	Examiner	Sequentially list conditions, if any, leading to innectate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):										
Š	cate be executed physician and the burial-transit	E E	resulting in death) East	Due to (or	r as a conseq	uence of):							
	ficate physi s the l	edical		►d									
4	leath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			7				2	23d. Date of del	very
	e death	sicia	in the past 12 months? 1 □ Yes 2 □ No		th 2□Feta nt at time of o		Other (	pregnancy specify)				Month	Day Year
	w requires that the d been signed by the should be detached	Phy	9 ☐ Unknown  Part II. Other significant conditions			ulting in the u	and orbiting	onuca given in Do	net I	23o Did	tobacco u	eo contributo to	the cause of death?
5	uires ti signe d be d	j by	Malnutrition	contributing to dea	ur but not res	alang in the a	indenying	cause given in Fa	aiti.				obably 4 🖾 Unknown
5	w requ	Completed	Ileus							24a. Was	an	24h Were au	tonsy findings available
2	The la te has age 2	шо	TICUS							auto		prior to death?	topsy findings available completion of cause of 2 No
3	ian: rtifica ctor, p	BeC	25. Was case referred to medical examiner?					26. Pl	lace of Deat	1  Yes th (Check only		1 Tes	2 110
5	hysic this ce al dire	은	1 ☐ Yes 2 🛣 No	Hospital: 1 1 Inp		ER/Outpatie			Nursing Ho			6 □Other (Spe	cify)
5	ding F	ion:	27. Manner of Death  1 X Natural 5 Pending 2 △ Accident investigation		Injury , Day Year)	28b. Time o Injury	M	28c. Injury at Work? 1 ☐ Yes 2	. □No	28d. Describe	how injur	y occurred	
	*Attending Physician: The lav ar death. rector: After this certificate has by the funeral director, page 2	ficat	3 Suicide 6 Could not t	28e. Place o	of injury - At h	ome, farm, sti				28f. Location	Street an	d Number or Ru	ıral Route Number,
5	tal or s after al Dire	Certification:	Homicide determined building, etc. (Specify)  City or Town, State)										
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as												stated. to the cause(s)
	o the ithin 2 o the I	Medical	29b. Signature and title of certifier	and manne	er stated.			9c. License numbe				te signed (Mont	
	%	_	1/4	$\rightarrow$	/	M		D58681				ne 6, 20	
1	ALL		30. Name and address of person who	completed cause	of death (Iter	n 23a) (Type,	Print)						
1	),		Jude Alexander				Cent	er Drive,	, Rock	cville,	Mary	land 2	.0850
	Sta Registr		31. Date filed (Month, Day, Year)	2007	gistrar's Sign	ature		, .					

DHMH 17 Rev 1/2001

			1- For State of Maryland / Dep	artment of Health and rtificate of Death	, ,	iene 007 20185
,		ш	Decedent's Name (First, Middle, Last)	,	2. Date of Deat	
100	Physici	_	Cooper III linke	inc Sr	June Month	3 2007 07:30 A <sup>M</sup>
	/Medic	See Pro	4a. Facility Name (If not institution, give street and number)	4b. City Town, or Location of Dea		4c. County of Death
	Examir	ier	Union Hospital	E1kton		Cecil
- yel-	Francis		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8. Date of Birth	9 Birthplace (State or Foreign
н	Funeral Director		721-18-1572 1ÄM 2□F 81 Yrs.	Months Days Hours Min	. (Month, Day,	Country) , 1925 Pennsylvania
	Na form		Usual Residence of Decedent		Aug. 23	, 1929 Tellisylvalila
	/lanc		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Man fled	to	Maryland Cecil Elkton	า		1 XYes 2 □ No
	the	rec	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Country?
	3a ou		16 Chesapeake Road	21921		USA
	ms 2	Funeral Director		Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - American Indian,
10	r iter	교	1 ☐ Never Married 2X Married 1 X Yes 2 ☐ No		rto Rićan, etc.)	Black, White, etc.
33	al", o	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: WWII	1 ☐ Yes 2 X No Specify:		Specify: White
215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	Completed	15. Decedent's Education 16a, Dece	edent's Usual Occupation		16b. Kind of Business/Industry
715	in 7 in "in Medi	ple	(Specify only highest grade completed) (Giv. Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of wo DO NOT use retired)	orking	
212	filed withi Hygiene. other than ent, the M	E		tenance Man		Manufacturing
	othe ent,	ВеС	17. Father's Name (First, Middle, Last)	18. Mother's Na	me (First, Middle, I	Maiden Surname)
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylar it of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show it item 27 is marked other than "natural", or items 25a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	To B	George M. Wakeling	Vern	a C. Rhod	ls
<u></u>	should ind Men s marke umatic	-	19a, Informant's Name/Relationship (Type. Print) 19b. Mail	ing Address (Street and Number or F	Rural Route Number	; City or Town, State, Zip Code)
N	od 2 lith a 27 is r trau		Florence R. Simon Wakeling/wife 16			
ā,	Health tem 27 i		20a. Method of Disposition 20b. Place of Disp	osition (Name of		20c. Location - City or Town, State
0	Pages nent of 8 ant: If ite ary or o		1 XI Bunal 2 Cremation 3 CHemoval from State	ematory or other place)	2 2007	7 : J DA
Baltimore,	it. Purtue		21 Signature of Augustal Saniga Linears on	22 Name and Address of Facility		Linwood, PA
Ba	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra		21. Signature of different Service License	R. T. Foard Funer 111 S. Queen Stre	al Home,	P.A.
			23a. Part . Enter the disease, or complications that caused the death. Do not en			
			shock, or heart failure. List only one cause on each line.	ner the mode of dying, such as cardi	ac or respiratory arm	est, Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)  a. End Stage	lenal to	ILUVE	/mo
	/Medical Examiner		Due to (or as a consequence of):	11 1.11	/	./
	LAGITITICS		Sequentially list conditions. b. Metastatic	CRAV (Ell	avein	oma 4mo
	p #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	, ,	1 . 11	
	scute ind trans	am	that initiated events c.	imphocytic	KUKEN	nia 241
0,	e exe	Ě	Due to (or as a consequence of):	7		
8760,	icate be executed physician and the burial-transit	dical	d			
9	rtifica ng pl	Med	IF FEMALE:		-	
Вох	death certifi e attending d for use as	an/I	23b. Was decedent pregnant 23c. If yes, outcome pt pregnancy	□Ectopic pregnancy		23d. Date of delivery
	death at at a fo	sici	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5	Other (specify)		Month Day Year
P.0	that the death certificed by the attending potateched for use as	Physician/Me	9 Unknown			
	The law requires that the ate has been signed by the bage 2 should be detache	by F	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tol	bacco use contribute to the cause of death?
Records,	w require been sig should b		1.		1 □ Y	es 2 No 3 Probably 4 ☑Unknown
S	s been s been s shoult	Completed			24a. Was a	n 24b. Were autopsy findings available
æ	he la e ha	Ē			autops perfor	med2 death?
Vital			25. Was case referred to medical	Of Place of D		2. No 1 □Yes 2 No
>	Physlcian: The law this certificate has tral director, page 2 s	Be c	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatie	Other:	eath (Check only on	
0	Physic this gral di	: To	27. Manner of Death 28a. Date of Injury 28b. Time	THE PERSON AD INDIVIDUAL		ence 6 Other (Specify) ow injury occurred
on	ding F h. After funera	tion	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		,,
Division	Attending in death.  ector: After by the fune	Certification:	3 Suicide 6 Could not be 280 Pleas of injury. At home form of		28f Location (S	treet and Number or Rural Route Number,
$\leq$	after Dire	irti	4 Homicide determined 20e. Place of Injury - Actionie, Ialin, S		City or Town	n, State)
	To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and also	ne and due to the o	ausa(s) and manner as stated
	Hos 24 hc Fun tely	Medical	(Check only one)    Check only one   Check only   Check only   Check only one   Check only	nvestigation, in my opinion, death oc	curred at the time, o	late and place, and due to the cause(s)
	thin the	Mec	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Month, Day, Year)
	F X F S		1 1 1 1 1	0 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		and digital (month, pay, real)
			Jawaia a farry no	125915		6-3-01
	~ //		30. Name and address of person who completed cause of death (Item 23a) (Type	214 EIK	1-1-1	110
1	ZIVA		31. Dale filed (Month, Day, Year) 32. Revistrar's Signature	217 211	100	1110 21721
	Sta Registi		31. Date filed (Month, Day, Year) 32. Refestrar's Signature	goode	,	

			1 - For State Registrar	State of Marylar	•	nent of Health and I cate of Death		iene 19. No.	100	2018a
			1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month	h Day	Yeer	3. Time of Death
	Physici /Medio		George H	. Ward	ST.		6	5	07	7:30 A.M.
	Examin		4a. Fecility Name (If not institution, give s	treet and number)	4b.	City, Town, or Location of Dealf	1	4c. Coun	ty of Deeth	/
			5630 ANIEL	Road	(	Tirdletree		Wo	rce.	ste-
	Funeral		Social Security Number     6. Sex	7. Age (In yrs.	Mo	Under 1 Year   If Under 24 Hrs. nths   Days   Hours   Min.	8. Date of Birth (Month, Day,	Year)	9. Birth	plece (State or Foreign htry)
	Director		201-10-1010	M 20 F 77	Yrs.		8-10	3 ()		Ind.
	pue *		Usuel Residence of Decedent  10a. State 10b. County	10c. Ci	ly, Town or Location	1				10d. Inside City Limits
	•ho	ō	Mal III	1.	_111					1 ☐ Yes 2 PNo
	28a-f	ect	10e. Street and Number	Ter Iti		<u>ე</u> ექ. Zip Code	1.	Og. Citizen o	What Cou	
	with a or	ă	5 / 2 A A A A	Parl	l N	71070	,	9. 01126110	· Wilat Cou	
	s 23	Funeral Director	11. Marital Status	2. Was Decedent Ever in U	S 13 Was	Decedent of Hispanic Origin? (S	pecify Yes or No-	14. B	ace - Ameri	can Indian.
	ltarr Itarr	Ë	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No	If Yes	, specify Cuban, Mexican, Puert	o Rican, etc.)	BI	ack, While,	elc.
336	lrs al	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	101	es 25 No Specify:		Spec	ity: R/	ack
21215-0036	72 hours after death with the Maryland naturel', or Itams 23a or 28e-f ehow dical Ezama'ne must be notified at	Completed	15. Decedent's Educ		16a. Decedent's	Usual Occupation		16b. Kind of	Business/In	ndustry
215	hin 7 hin 7 Medi	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO N	of work done during most of wor OT use retired)	rking		1	Λ
2	giene giene er the	0	12+6		lteau E	Equipment Op	crafor 1	Norce	stor	- County Roals
	be filed within stal Hygiene. Ind other than "event, the Mer	Be (	17. Father's Name (First, Middle, Last)	, ,	7	18. Mother's Nan	ne (First, Middle, M	Aaiden Suma	ime)	/
<u>Ja</u>	should be nd Mental marked c	일	Percy Thomas	Ward		HNNic	(ON	JOF		
Maryland	and and is m		19a. Inform t's Name/Relationship (Ty)	pe, Print)	19b. Mailing Ad	dress (Street and Number or Ru	ral Route Number	City or Tow	n, State, Zip	Code)
	1 and 2 Health tam 27		HAN HODDER (	laughter	5630.6	Nley Koad	Girdle	trec	md	,21829
altimore,	of He of Hitar		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	8 1 /	Place of Disposition cometery, cremator	(Name of / y or other place)	Date	20c. Location	- City or To	own, Slate
Ĕ	permit. Pages Department of Important: If it Important: If it any injury or o		*4 Donation 5 Other (Specify)		aruland U	ot, Con. 16-1	2-07 1	Beaul	ah 1	nd.
alt	permit. Pag Department Important: I any injury c		21 Signature of Functal Service License	е /		ne and Address of Facility $\mathcal{B}_{d}$	everse Sr	nith	Fun	oral Hone
8	20549		Massil		917	Isaballa Stre	ct, Sal	ishur	4, m	1. 21801
П			23a. Part1. Enter the disease, or compli shock, or heart failure. List onty on	cations that caused the deat e cause on each line.	h. Do not enter the	mode of dying, such as cardiac	or respiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		456VD					Onset and Death
	/Medical		resulting in death)	Due to (or as a consec	juence of):					
П	Examiner		Sequentially list conditions			· · · · · · · · · · · · · · · · · · ·				
	D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	juence of):					
	ecute and trans	аш	Cause (Disease or injury that initiated events resulting in death) Last							
00,	death certificate be executed e attending physician and of for use as the burial-transit		rosaming in south, sast	Due to (or as a conseq	juence or):					
8760,	ate to	Physician/Medical		•						
9	eath certific attending pl	Me	IF FEMALE:	Do Maria automa of progra						
Вох	ath c	lan	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Feta	il death 3 ☐Ecto	pic pregnancy			ate of deliving	ery Day Year
<u>.</u>	se de the a	/sic	1 Yes 2 No	4☐ Pregnant at time of c	leath 5∐Oth	er (specify)		ļ		
P.0	law requires that the de as been signed by the a 2 should be detached f	P.	Part II. Other significant conditions con	tributing to death but not res	ulting in the underly	ving cause given in Part I	23e. Did tob	acco use co	ninbute lo t	he cause of death?
ds,	w requires that been signed b should be det	i by	•	<b>,</b>	,	, j	1 X Ye			bably 4 Unknown
Ö	requ	etec					7			
Sec	has i	Completed					24a. Was ar autops perform	y	prior to co death?	opsy findings available impletion of cause of
al F	cate h						1 ☐ Yes 2	No		2□ No
Vital Records,	Physician: The la ribis certificate har ral director, page 2	Be	25. Was case referred to medical examiner?	ospital:		Other	ith (Check only on			
ot	Phys this al dir	. To	1 Yes 2 No	1 Inpatient 2 28a. Date of Injury	ER/Outpatient 3	_ DOA   4 _ Indising is	ome 5 K Reside			(y)
	After funer	io	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	280. Describe no	w injury occi	med	
isi	death death stor: / the	ical	2 Accident investigation 3 Suicide 6 Could not be	28e. Placa of Injury - At h			28f. Location (St.	reet and Nun	nher or Ruc	al Route Number
Division	or A after Direct in by	Certification:	4 Homicide determined	building, etc. (Special		actory, office	City or Town		1007 01 7 107	ar riodio ivambor,
	To the Hospitel or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying Phys	ician: To the hest of my key	owledge death occ	urred at the time, date and place	and due to the or	usple) and -	nanner as a	stated
	24 h	Medical	(Check only 2 Medical Examir	er: On the basis of examina and manner stated.	ition and/or investig	ation, in my opinion, death occu	rred at the time, da	ate and place	, and due t	o the cause(s)
	o the	Me	29b. Signature and title of certifier			29c. License number	2:	9d. Date sign	ed (Month,	Day, Year)
	+3+8		Natr			047094			707	
h	10 m		30. Name and address of person who co	moleted cause of death /Iter	n 23a) (Tune Print	,		-/4	101	
1	Tr		Vel Name and address of person who co	W 1415	5. DIVIS/	047094				
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature					
	Registr		JUN 0 8 20	07		M.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #26 Per Phy G868 6/22 Perfifigate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Antlitz Myrtle Lee June 20 2007 8:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Co. Glen Burnie 241 Turnwood Drive 8. Date of Birth (Month, Day, Year) Feb. 28, 1906 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral**  Birthplace (State or Foreign Country) 1 M 2 F Days 213-20-2990 Director 101 Virginia Usual Residence of Decedent r 28a-f show notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Yes 2□No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 2 iner must be n 552 East Fort Avenue 21230 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status an "natural", or Iten Medical Examiner Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Be Completed by 3 Widowed 4 □ Divorced Specify: White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) other traumatic event, the 10 N/A Self Employed Seafood Company other 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental ⊢ ျှ Mary Charles Adkins Beasley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert B. Antlitz (Son) 241 Turnwood Drive Glen Burnie, Maryland 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Pk. 106/22/07 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility Cully-Polyniak Funeral Home, P.A. O East Fort Avenue Baltimore, Maryland 21230 McCi 130 23a. Part1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) DURY 201 /Medical Due to (or as a consequence of Examiner mo on Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, 0 that initiated events resulting In death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ★ No 24a. Was an certificate has autonsy perforn 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No 4□ Nursing Home 5 Residence 6 (Twither (Specify)) residence Other: 1 🔲 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Manner of Death
1 Natural
2 Accident 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 ☐ Yes 2 No s after death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) þ 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

31. Date filed (Month, Day, Yeld

JUN 2 2 2007

32 Registrar's Signature

07-04636 Brian D. Atkins

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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			For State			(	Certifica	ate of	Death				. Date of De	Reg. No	) <u>.                                    </u>		3. Time of	Death
Phys	siciar		egistrar . Decedent's Name (First, Midd	rar edent's Name (First, Middle,Last)										Day	Ye	ar	1745	
	amin		Brian D. Atki	ne									Month June 17,			of Dooth		
			a. Facility Name (if not institution	on, give s	treet and nu	umber)		4	b. City, Tow	n, or Lo	ocation of	Death			lc. County			
			1112 Vanguard Way						Bel Air						Harford			
_		- 5	. Social Security Number	6. Sex		7. Age (In	yrs. last birt	thday)	If Under	1 Year	If Under		8. Date of I	Birth (MI	WDD/YYY	Forei	thplace (Sta	
Fune		l°							Months	Days	Hours	Min.	Nov.	10	107	C	ountry) 575	rginia
Direc	tor.		212-92-5404	1 X N	1 2 F	30		Yrs.					NOV.	10,	197	01	V.I	rya.
			Isual Residence of Decedent			1400	: City, Town	or Locatio	on								10d. Insid	le City Limits
	any	[1	0a. State 10b. County			100	. City, Town	Of Locali									1 Ye	≈ 2 🔻 No
힏.	Ce. w	_	Maryland Har	ford		1	Be1	Air						10. 0	itizen of V	What Cou	intri/2	21
rylar	a-f	윉	Oe. Street and Number						10f. Zip C	ode				10g. C	itizen or v	VIIat Cot	atti y :	
e Wa	ied a	Director	1112 Vanguard	Way	,				21	.015				Ur	nited	Sta	tes_	
÷	or items 23a or 28a-f show must be notified at once.				12. Was De	ecedent Eve	er in U.S.	13. Wa	s Decedent	of Hisp	anic Orig	jin? ( Spe	ecify Yes or	No-			rican Indiar	, Black,
h wi	t be		11. Marital Status 1 X Never Married 2	Married		Forces?		If Y	es, specify	Cuban,	Mexican,	, Puerto I	Rican, etc.)		. •	ite, etc.		
deat	or it	声	44		1 Yes	2 X	No	1	Yes 2	ζ No	specify:				Specify	· Wh	ite	
after	ner,				or Dates:		160	Deceden	r'e Henal O	ccupation	on (Give	kind of w	ork done	16	o. Kind of	Business	s/Industry	
ours	x sm	Completed by	15. Decedent's Education (Sp.				ileu) Toa.	during m	nost of work	ing life.	DO NOT	use retir	ed)	1				
72 h	n" a	ig	Elementary/Secondary (0-12	2)	College	(1-4 or 5+)	İ	Sale	2.5					- 1 -	Retai	1 Sz	les	
D36	eg p	위	12 years					Sare	-5		10 Mathor	de Name	(First, Midd			_		
ygie	be N	ত্তা	17. Father's Name (First, Midd	le, Last)						- 1						,		
e file	nt, t	-	William I. Sh	ell.	Sr.						Bre	nda	K. At	kin:	S City of T	ourn Sta	te Zin Cod	e)
212 Jid b	mar!		William L. Sh 19a. Informant's Name/Relatio	nship (Ty	pe, Print)		1	9b. Mailin	g Address	(Stree	t and Nur	mber or F					ite, Zip Cod	
MD 21215-0036 12 should be filed within <sup>7</sup> Ith and Mental Hygiene.	7 is	-	Clara E. Wils		(Aunt	)		2011	Timbe	rne	ck D	rive		ings	, <u>Ma</u>	ryla	nd 20 or Town, St	736
nd 2	raut	ŀ	20a Method of Disposition					of Dispo	sition (Nam ther place)	e of cer	netery,		Date	2	oc. Location	on - City	or rown, St	ale
S L S	F F	-	1 X Burial 2 Cremat	ion 3	Remova	I from State				L 0.761		6/21	/2007	. [,	Ral+i	more	- Mar	yland
Page Page	r ot	Oak Lawn Cemetery 6/ 4 Denotes of Funcial Specify: 22. Name and Address of Facility										7 200 7		Darer	IIIOI (	, Hai	. y ±ana	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	port	- [	21. Signature of Funeral Servi	ce Licens	see								Home	of :	Dunda	ılk,	Inc.	
<b>`</b> ````` § §	E.E.		3a. Part I. Enter the disease,	nes				79	922 W.	ise	Aver	ue	Dunda	1k,	Mary shock or	heart	3 2122 Appro	ximate Interval
ıvsi	cian		3a. Part I. Enter the disease, failure. List only one cau	or compl	lications tha	t caused th	e death. Do	not enter	the mode o	it dying,	such as	cardiac	i respirator	y allost	SHOOK, OF		Betwe	een Onset and Death
/Med					Cardia	ac arrt	nythmia	, duct	o bor	der1:	ine ca	ardio	negaly	with	epica	rditi	ls and	
Exam	niner		Immediate Cause (Final disea or condition resulting in death	)	Due to (or a	s a consequ	uence of):	biv	entric	ular	dila	tatio	n					
				b.												_		
		-6	sequentially list conditions, if any, leading to immediate		Due to (or a	s a conseq	uence of):											
		miner	cause. Enter Underlying Cau (Disease or injury that initiate				_	_	_				_	-				
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exec	an a	<u> </u>	X UNPENDED		AMENDE	27 701	rME. g8	69 7	/10/07	7/1	23a,p	erÆ,	g869, 1	//16/	0/ 11			
6 y	ysic bur	/Medical	IF FEMALE:		23c. If y	es, outcome	e of pregnan	ıcy							23d. Da Mon		very Day	Year
876 iffica	ng phy	5	23b. Was decedent pregnant	in the	1 Li	ve birth		2	Fetal death	3	Ecto	pic pregr	ancy		IVIOIT	uı	Day	
. 60 E	endii use a	Si.	past 12 months?		,	egnant at ti	ime of death	5	Other (Spe	cify)					1			
Box 68760, death certificate b	gned by the attending r e detached for use as th	Physician		Unknow	9 0	nknown						5 //	1220	Did toh	acco use o	contribut	e to the cau	se of death?
the	by th	占	Part II. Other significant co	nditions	contributii	ng to death	but not resu	Ilting in th	e underlyin	g cause	given in	Part I.						4 V Unknown
Division of Vital Records, P.O.	gned e det	Completed by												165				
S,	as been sign should be o	led											24a.	Was all		4b. Wer	e autopsy fi r to complet	ndings availablion of cause of
ord w rec	shot	l e											•	perform	ned?	dea	th?	2 No
) Se la	te ha	ا ج												Yes 2	No	1 🗸	Yes	2 140
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icia <b>Ital</b>	s cert	å	examiner?		Hospital:	Inpatier	nt 2 El	R/Outpati	ent 3	DOA	Other <sub>4</sub>	Nurs	sing Home	5 F	Residence	6	Other: Scen	9
> S &	r this	<u> </u>	1 Yes 2 No		28a I	Date of Injur		8b. Time	of Injury	28c. In	jury at W	ork?	28d. Des	cribe h	ow injury o	ccurred		
	Afte	ج ا	1 X Natural 5	<b>5</b>	1200.(1	Month, Day,Ye	ear)			1	Yes 2	No						
F O D	eath.	i	2 Accident	Pending Investiga	ition				Visit factor	nu office	o building	etc	28f Loc	ation (S	treet and I	Number	or Rural Ro	ute Number, Cit
r At	irect irect	<u>`</u>	3 Suicide 6	Could no	28e	Place of Inj	jury - At hom	ne, farm, s	street, factor	ry, omce	e bulluling	, 610.	or T	own, St	ate)			
in in in in in in in in in in in in in i	irs af	Certification: To	4 Homicide	determin		ecify)								-		_		
lospi	t hou	9		ng Physi	cian: To th	e best of my	y knowledge	e, death o	ccurred at the	ne time,	date and	i piace, a	nd due to th	ne caus	e(s) and m	anner as	stated.	e(s)
be II	within 24 hours after death.  The firmeral Director: After this certificate has been signed by the attending physicic remains by the firmeral forcetor. After this certificate has been signed by the attending burity has been signed by the defaabled for use as the burity and the signed by the sign	Medical	29a. Certifier 1 Certifying Check only 2 Medical	Examin	er:On the b	asis of exar	mination and	d/or invest	tigation, in r	ny opini	ion, death	occurre	a at the time	e, date a				
Tot	To t	3   2	29b. Signature and title of c		and man	ner stated.			2	9c. Lice	ense num	ber			29d. Dat	e signea	(Month, D	ay, Year)
		2	29D. Signature and title of C							0.0	C.M.E.				June 1	8, 200	)7	
			alles,															
	A.		30. Name and address of p	erson wh	o completed	d cause of c	leath (Item 2	23a)		D-III		AD O40	201					
	φ		Ana Rubio MD.	Assist	ant Medi	cal Exan	niner 1	11 Pen	n Street		more, N	VID Z IZ						
		Stat	a 31. Date filed (Month, Day,	Year)	13	Registra	ar's Signatur	e A	we									
				2 20	107	FT. A. 12	A A DE	Palma	N. Carlotte									

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-04590 arian Brown	Please Type or Print in Black Indelible State of Maryland / Department	of Health and Mental Hy	s Are Legible. giene	m, mag t						
Physician/ edical Examiner	1- For State Registrar  1. Decedent's Name (First, Middle,Last) MARIAN A. BROWN	or Deatri	Reg. No.  2. Date of Death  Month Day Year  June 16, 2007	3. Time of Death 0912 hrs						
	4a. Facility Name (if not institution, give street and number) Union Memorial Hospital	4b. City, Town, or Location of Death Baltimore	4c. County of Dea ${ m N/A}$							
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 17-84-5515 1 M 2x.F 35	If Under 1 Year If Under 24Hrs.  Months Days Hours Min.	Fore							
ow any	Usual Residence of Decedent	cation TIMORE CITY		10d. Inside City Limits 1 X Yes 2 No						
the Maryland a or 28a-f show tified at once.	10e. Street and Number 661 DUMBARTON AVENUE	10f. Zip Code 21215	10g. Citizen of What Co	untry?						
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene Ty is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) White, etc.	erican Indian, Black,						
"natural", c	Lor Dates:	Yes 2 X No specify: dent's Usual Occupation (Give kind of v g most of working life. DO NOT use reti								
5-0036 lied within 72 hour Hygiene Lother than "natu the Medical Exar Completed	12 C	ASHIER 18.Mother's Name	WAL-MAR (First, Middle, Maiden Surname)	T CORP.						
, MD 21215-00 and 2 should be filed with teath and Mental Hygien ten 27 is marked other traumatic event, the Meronal To Be Corr	JAMES BROWN  19a. Informant's Name/Relationship (Type, Print )  19b. Ma	iling Address (Street and Number or F	ANNIE THOMAS  Imber or Rural Route Number, City or Town, State, Zip Code)  PRING IN APT C. MD 21215							
ore, lest and of Healt If item	20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  20b. Place of Discrematory of MF.TRO	00 W. COLDSPRIN position (Name of cemetery, r other place) CREMATORY 6/	Date 20c. Location - City							
Baltimo permit. Pag Department Important: injury or ot	4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee	2. Name and Address of Facility HC	WELL FUNERAL H	TIMORE, MD						
Physician Medical Examiner	276 Perf. Enter the disease, or complications that caused the death. Do not enter follows. List only one cause on each line.  In rediate Cause (Final disease a. Hy ertensive cardiovasc		r respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death						
Jer	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate out to (or as a consequence of):  Due to (or as a consequence of):									
ecuted and - transit										
			23d. Date of deliv							
). Box 68760, the death certificate be expression by the attending physician ched for use as the burial physician Medic	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 V Unknown  1 Live birth 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregna Other (Specify)	ancy Month	Day Year						
s, P.O. Boiries that the designed by the dectached for the dectached for the boundary by Physics 1 and 1 by Physics 1 and 1 by Physics 1 and 1 by Physics 1 and 1 by Physics 1 and 1 by Physics 1 and	Charity	he underlying cause glven in Part I.	23e. Did tobacco use contribute  1 Yes 2 No 3 P	robably 4 🗹 Unknown						
ords  v requ s been should										
Vital Recc ysician: The lan his certificate ha director, page 2	o 25. Was case referred to medical 25. Place of Death (Check Only One)  Examiner?   Hospital:   Inputient 2   FR/Outpatient 3   DOA   Other   Nursing Home 5   Residence 6   O									
on of Vil anding Physic th. After this he funeral dir-	27 Manner of Death 28a Date of Injury 28b. Time		28d. Describe how injury occurred							
Division of Vote Hospital or Attending Physinia 24 house after death.  To the Funeral Director: After to completely filled in by the funeral Joint Confilled in Confil Con	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, (Specify)	street, factory, office building, etc.	28f. Location (Street and Number or or Town, State)	Rural Route Number, City						
To the Hosp within 24 hc To the Fun completely	29a. Certifying Physician: To the best of my knowledge, death of one)  2 Medical Examiner:On the basis of examination and/or investigation and manner stated.	ccurred at the time, date and place, an- tigation, in my opinion, death occurred 29c. License number	d due to the cause(s) and manner as s at the time, date and place, and due to 29d. Date signed (i	the cause(s)						
	hig hi, mo	O.C.M.E. June 17, 2007								
(5)	30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn S  31. Date filed (Month, Day, Year)  32. Reg (trar's Signature)	treet, Baltimore, MD 21201								

ORIĞÎNAL

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #2 Per Phy G868 6/22/07CeHificate of Death Reg. No. 2. Date of Death Jun. 17, 2007 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Francis Lynch Bull /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KEHAN ARTOR HEALTH AND AIR SEL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday **Funeral** 1⊠M 2□F Yrs. Director 21, 216-22-3821 81 Maryland Usual Residence of Decedent the Marylend 10b. County 10d. Inside City Limits 10a State 10c. City, Town or Location worle f Health and Mental Hygiene. Item 27 is marked other then "neture!", or Iteme 23a or 28a-f ehov other treumatic event, the Medical Examinar must be notified at 1 ☐XYes 2 ☐ No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 126 N. Hickory Avenue 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "neturel", or Item any Injury or other traumatic event, the Market 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 Groundskeeper Town Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Milton James Bull Annie May Elliott 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth A. Wildason / Niece 230 Victory Lane, Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 6-20-07 Towsen, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiopulmonary **Physician** /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 ☐ Unknown ۾ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1∐ Yes 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one 1 Yes 2 Ho Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 6 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) 006398 June 18 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 669 Revolution Lee , UD Benjamn

State Registrar 31. Date filed (Mohiti Day) Year) 200

32: Registrar's Signature

		State of Maryland / Department of Health and M  1- State Certificate of Death	nental Hyg	211117	20191
				eg. No.	1.0101
Physici /Medic		1. Decedent's Name (First, Middle, Last) George Francis Beck	2. Date of Dea Month June 19	Day Year	3. Time of Death 7:00 P M
Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Death	
		Genesis Health Care Center Waldorf		Charles	3
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
Director		577 46 4340 TXX 2 F 72 Yrs. Months Days Hours Min.	Dec 19,	1934 Wash	nington DC
inc., intellylation Z. (Z. 13-0030) s. 1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene. if Heath and Mental Hygiene. other traumatic event, the Madical Examinar must be notilised at	٦.	10a. State 10b. County 10c. City, Town or Location  Maryland Prince George's Upper Marlboro			10d. Inside City Limits 1 ☐ Yes 2 X No
Ne M	Funeral Director				
with 1	ă	10e. Street and Number 10f. Zip Code		log. Citizen of What Co	•
ath v	ra E	8537 Grandhaven Ave 20772		United S	
tem de	nne	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
S afte	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No If Yes Give ↑ 1 □ Yes 2 ☑ No Specify:  3 □ Widowed 4 ☑ Divorced Year of Dates:		Specify:	White
ural far				· · · · · · · · · · · · · · · · · · ·	
72 72 I	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work	king	16b. Kind of Business/I	ndustry
afthin a	цп	Elementary/Secondary (0-12)  College (1-4or 5+)  Iile. DO NOT use retired)		D 1	
Martina 1	ပ္ပ	12 4 Trust Officer		Financial	
ing, wally falled withing stand 2 should be filed within the after and and a hygiene. Item 27 is marked other than other traumatic event, the Ma	Be		- ,,	Maiden Sumame)	
Ments Alents rked tice	To	Edward Beck C	ecelia	Pitts	
Should have		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Run	ral Route Number	r, City or Town, State, Z	ip Code)
and 2 and 2 ealth a m 27 is		Linda Beck (Daughter) 8537 Grandhaven Ave,	Upper Ma	rlboro, MD	20772
the Head		20a. Method of Disposition  20b. Place of Disposition (Name of cometery, crematory or other place)  20c. Method of Disposition (Name of cometery, crematory or other place)		20c. Location - City or	
permit. Pages Department of I Important: If Its any injury or of		ALADUNAL 2 Commation 3 Chemioval from State		D . 1	M 1 1
ritme ritme		4 □Donation 5 □Other (Specify) Fort Lincoln Cemetery  21. Signatury of Funeral Section See 22. Name and Address of Facility I.e.		Brentwood,	
permit. Departrimportul					
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To the Hospital or Attending Physicien: The law requires that the death certifical within 24 hours after death.  Within 24 hours after death.  Completely filled in by the funeral director, page 2 should be detached for use as the	Medical (	29a. Certifier (Check only (Ch	and due to the c	ause(s) and manner as	stated.
the I the I	Ned	one) and manner stared.			
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0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			t t.
8		George Wathen, M.D. 11345 Pembrooke Square # 103, Wal	dorf, MD		
Sta		31. Date filed (Month, Day Year) 32. Registrar's Signature	•		
Registr	ar	JUN 2 2 2007 Beren St Joseph			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Betters Aonth **Physician** Charmaine June 20 2007 10:02 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 4526 Hazelwood Avenue Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Çquntry)
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 **Funeral** Months Hours Days Maryland 212-70-7554 nov. 26, 1 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show must be notified at Baltimore Director Maryland 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 4526 Hazelwood United States 21206 Funeral items ? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian the Medical Examiner Black White etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 ☑ No Specify: þ Specify: Black 3 XWidowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry BWI Airport Elementary/Secondary (0-12) College (1-4or 5+) Service Worker permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens important: If item 27 is marked other that any injury or other traumatic event, the any once. 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leon Betters Yearl Ewell 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Latissia Rayfield-Daughter 4526 Hazelwood Avenue Baltimore, MD. 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland KM9 Memorial Park 4 Donation 5 NOther (Specify) Entembrant 2007 21. Sig Ture of Funeral Service Licensee Calvin Address OF Applians Funeral Service, P. A P.O. Box 11651 Baltimore, Maryland & 1229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death METASTATIC COLON CANCER Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: Tha law requires that tha death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autops, performed 1∐ Yes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Besidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA after death.

I Director: After this of in by the funeral di 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 2 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifie 29c. License number 29d. Date signed (Month, Day, Year) n who completed cause of death (Item 23a) (Type, Print)

State Registrar 31 Date filed (Month, Day,

Year)

DHMH 17 Rev 1/2001

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32 Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 4:55 PMM 2007 June 18, Michael Windham Brown /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Suburban Hospital Bethesda Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. **⊅**K¹M 2□ F 57 MS 12/27/1949 587-42-7450 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State notified at 1 ☐ Yes 2 No Director MS Jones Ellisville 28a-f 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 23a or must be USA 39437-15 Arrington Rd. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. "natural", or item ledical Examiner 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White \$ 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 7 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Drilling Oil Company Elementary/Secondary (0-12) College (1-4or 5+) Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Doris Wilma Baker Nolan Mathew Brown ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Amy Corley/Daughter 15 Arrington Rd. Ellisville, MS 39437other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Iter
any Injury or ott Jun 22 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory 2007 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Rapp Funeral & Cremation Services
933 Gist Ave. Silver Spring, Maryland 20910-Rapp Funeral & Cremation Serving, 933 Gist Ave. Silver Spring, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician days Sepsis /Medical Due to (or as a consequence of): Examiner Abscess Panerentic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and al-transit The law requires that the death certificate be executed Alcoholism Due to (or as a consequence of): attending physician a for use as the burial-Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 2No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

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1 Yes 2 No page 2 s MDivision or Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No ٩ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after To the Funeral Dire To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 20, 2007 N 56652 MD H d address of person who completed cause of death (Item 23a) (Type, Print) SEVEN LOCK ROAD \$200 POFFENROTH ROCKUILLE MD MATTHEW 1201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) Month Year **Physician** June 18. 2007 6:42 Constance Marie Bamberger /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Columbia
Under 1 Year | If Under 24 Hrs.

Davs | Hours | Min. Howard County Rose Manor Assisted Living 8. Date of Birth (Month, Day, Year) 01/22/1918 Birthplace (State or Foreign Country) . Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2**X** □ F Months 215-09-8419 Maryland 89 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland 10b. County 10a. State ral", or items 23a or 28a-f show Examiner must be notifled at 1 □Yes X□No Eldersburg Carroll Completed by Funeral Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21784 1326 Holt Court United States 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 **X**No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 🔀 No 3altimore, Maryland 21215-0036 Specify: 3 XWidowed 4 ☐ Divorced 'natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical Elementary/Secondary (0-12) College (1-4or 5+) State Government Office Clerk other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event Be Sadie M. Tarsia Samuel Portera 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1326 Holt Court, Eldersburg, Maryland 21784 Rosalie Mary Ritchie (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 06/20/2007 Baltimore, Maryland 4 Donation 5 ☐ Other (Specify) New Cathedral 22. Name and Address of Facility e of Foneral Service License Hubbard Funeral Home, Inc. 4107 WIlkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** nomors disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Box 68760, Be Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year ō in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a d be detached for Division or Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an JEDIGSSIM autopsy 2 No Coronary Hery Discas Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation s after de... al Director: Aft 1 ☐ Yes 2 ☐ No M 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral I

completely filled To the Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JUNE 18th 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deborah IENCE 2835 Smith Avenue, Pikesville, Maryland 21208 31. Date filed (Month, Day, Year) State Registrar 2007 DHMH 17 Rev 1/2001

ORIGINAL

		- For State		rtificate of De	alth and Men <i>ath</i>		Reg	No. 201	17 2
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)	10,000	0	0		Date of Death	Day Year	3. Time of Dea
lical Examin		KONNIE	HNORF				June 19, 20	07 4c. County of Dea	0144 hrs
		4a. Facility Name (if not institution, give : University of Maryland	street and number)		y, Town, or Location Itimore	oi Death		4c. County or Dea	uı
Funeral	4	5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday) If U	Inder 1 Year If Und			(MM/DD/YYYY) 9. B	
Director		2/8-//-0954 120	1 2 F 2/	Yrs. Mo	onths Days Hour	s Min.	4-15	-1986 Fore	ountry) M L
and show any nce.		10a. State 10b. County	A BA	Town or Location	RE				10d. Inside Ci
the Maryls a or 28a-f tified at o	Director	1935 N. Coll	ing ton	AUE 10f.	Zip Code 2/2/3		10g	. Citizen of What Co	untry?
ms 23.	era	11. Marital Status	12. Was Decedent Ever in U Armed Forces?		edent of Hispanic Ori	igin? (Spe		14. Race - Ame White, etc.	erican Indian, Bla
after death	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No	1 Yes	2 No specify	<i>r:</i>		Specify: B	ACH
hours natur Exami		15. Decedent's Education (Specify only			ual Occupation (Give working life. DO NOT			16b. Kind of Business	s/Industry
0036 within 72 iene. er than "	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	5+	UDEN-		Cinca Mindalla Ma	sides Curema)	
	မ္က	17. Father's Name (First, Middle, Last)  Ronn, E ANDK	PE	Buno	y Se Ti	AN			Phillip
MD 2 d 2 shoult th and M n 27 is m.		19a. Informant's Name/Relationship (Tyl	Phillips						
_ = 2 = 2	ŀ	TIANDA BUNDY  20a. Method of Disposition	20b	1935 N Place of Disposition	Name of cemetery,	700	Date	20c. Location - City of	or Town, State
Baltimore, permit. Pages I a Department of He Important: If ite injury or other tr		1 Burial 2 Cremation 3	Removal from State	crematory or other pl	ace)	6-	232007	BAHO	12
Baltimord permit. Pages I Department of I Important: If injury or other		4 Donation 5 Other Specify: 21. Signature of Funeral Service License	P/_	22. Name	and Address of Facili	ity BA	600 MI	BA1+0	,,,
Dep Dep Initial	ŀ	khilbi bli dilles	teo	Phillip	O A WEAT	hERfo	RO F13	2431 1	OlivER .
Physician		23a. Part I. Enter the disease, or compli- failure. List only one cause on eac	cations that caused the deat n line.	h. Do not enter the mo	de of dying, such as	cardiac or	respiratory arres	st, shock, or heart	Approximate Between Or
/Medical Examiner			hotgun Wound to the						Dea
,		h	ue to (or as a consequence	ot):					
	ě		ue to (or as a consequence	of):					
	xaminer	(Disease or injury that initiated	ue to (or as a consequence	of):					
uted nd ransit	ш	events resulting in death) Last dd							
e exec	gica	UNPENDED	AMENDED						
Box 68760, e death certificate be execute the attending physician and ed for use as the burial - tran	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pre					23d. Date of delive	-
certification of the same of t	ian	past 12 months?	1 Live birth 4 Pregnant at time of 0	2 Fetal de		oic pregnan	icy	Month	Day \
Box e death the atte	ysi	1 Yes 2 No 9 Unknown	9 Unknown	o ouler (					
P.O. Boy es that the deatl igned by the att		Part II. Other significant conditions	contributing to death but not	resulting in the under	lying cause given in F	Part I.		2 ✓ No 3 Pt	
Division of Vital Records, P tal or Attending Physician: The law requires the safter death.  The Third of the This certificate has been signed to by the funeral director, page 2 should be d.	Completed by						24a. Was a		autopsy findings completion of c
e law le has ge 2 s	mp						perform	ned? death'	?
tal Reco		25. Was case referred to medical			26.Place of Deat	h (Check o			
Vital I ysician: his certifi director,	o Be	examiner? 1 ✓ Yes 2 No	espital: 1 Inpatient 2	✓ ER/Outpatient 3	DOA Other	Nursing	Home 5 F	Residence 6 Oth	ner:
of Vi ding Physic After this funeral dir	-	27. Manner of Death	28a. Date of Injury (Month, Day Year) Jun 19, 2007	28b. Time of Injury		[9	28d. Describe h	ow injury occurred	
Sion Attendi	Certification:	1 Natural 5 Pending 2 Accident Investigatio		0115 hrs	1Yes 2 •	No			
or Anather of Direct of Tin by	tific	3 Suicide 6 Could not b	28e. Place of Injury - At		ctory, office building,		or Town, St	treet and Number or late)	
Divisor Abours after neral Diversity of filled in I	Cer	4 Homicide determined	(Specify) Local Str					enue, Baltimore, M	
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tran	Medical	(Check only one) 2 Medical Examiner:	n: To the best of my knowle On the basis of examination and manner stated.	edge, death occurred a and/or investigation,	in my opinion, death o	occurred at	the time, date a	ind place, and due to	the cause(s)
F > F 0	ž	29b. Signature and title of certifier			29c. License numbe	er		29d. Date signed (A	Month, Day, Year)
		Laidett	Helav		O.C.M.E.			June 19, 2007	
_		30. Name and address of person who co	ompleted cause of death (Ite		et, Baltimore, M				

OCME

			For State Registrar	State of	of Marylar		artment			and M	lental Hyg	iene2 (	07	201	97		
	D		1. Decedent's Name (First, Middle	Last)							2. Date of Deal Month	th Day	Year	3. Time of De			
	Physici /Medic		Benton V	<i>I</i> . B	radley		,				June	20	2007	7:55	Рм		
1	Examin		4a. Facility Name (If not institution,	-	im <i>ber)</i>		4b. City,		Location of				ty of Death				
			7927 Tick Neck						asade				ne Arı				
	Funeral			6. Sex 1 [X]M 2 □ F	7. Age (In yrs.		If Under Months	Days	If Under Hours	Min.	8. Date of Birth	Year)	9. Birthi	place (State or F	-oreign		
	Director		216-12-6066 Usual Residence of Decedent			84 Yrs.	l1				Jan. 26	1923		MD			
	land I		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							0d. Inside City	Limits		
	Mary 1 • h	ō	Maryland Anne	Arundel				Pas	adena	l				1 ☐ Yes 2	. ⊠ No		
	28e	Je C	10e. Street and Number				10f. Zip	Code			1	0g. Citizen of	What Cou	ntry?			
	death with the Maryland me 23a or 28e-f ehow r must be notified at	Funeral Directo	7927 Tick Neck	Road					2112	2			USA				
	death	ner	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.	Was Deced	ent of Hi	ispanic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)		ace - Ameri ack, White,				
ဖွ	or its	Ē	1 Never Married 2 Marri	ed 1 √Yes	2 No		1 ☐ Yes 2		Specify:	i, rusito	rticari, otc.)	Spec		White			
2-003	erel',	d by	3 Widowed 4 □ Divorced	If Yes, G Year or I	Dates:												
2	be filed within 72 hours after death with the Marylar Ital Hygiene. d other than "neturel", or items 23a or 28e-1 ehow event, the Mudical Examinar must be notified at	Completed	15. Decedent (Specify only highes	s Education f grade completed	)	16a. Dece	dent's Usua kind of wor DO NOT us	k done d	ation du <i>ri</i> ng mos	t of work	ing	16b. Kind of	Business/Ir	dustry			
12	then.	m d	Elementary/Secondary (0-12)	College	(1-4or 5+)	me.	Guar					Natio	onal (	Suard			
2	be filed within tal Hygiene. In other than event, the M	ပိ	17. Father's Name (First, Middle, I	ast)		1	uuui	usili		er's Nam	e (First, Middle,			iuui u			
au		To Be	Edward S.	Brad	ley				Sal	1 y	Mae	Tul	11				
Maryland	d 2 should th and Mer ?7 ie marke treumatic	F	19a. Informant's Name/Relationsh	up (Type, Print)							al Route Number			Code)			
	C = W -		Diane Clodfelte	er (dau	ghter)	826	5 Sebr	ring	Cour	t, S	evern, M	4D 2114	14				
ē,	of Healt fitem 2 r other		20a. Method of Disposition		20b. I	Place of Dispo cemetery, crea	sition (Nan	ne of ther plac	(9)			20c. Location					
Ĕ	it. Peges artment of ortent: if it njury or o		1 ⊠Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp			en Have				6-d	3-07	Glen Bu	urnie,	Maryla	and		
Baltimore,	permit. Peg Department Importent: I any Injury o		21. Signature of Funeral Service	Funera dena, M		ne, P.A.											
'n			23a. Part1. Enter the disease, or	complications that	caused the dear	. Do not en								Approximate Interval Betwe	aen		
н	Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition   ERRBRAL TWFM  TWFM												ath		
т	/Medical		resulting in death)  Due to (or as a consequence of):												_		
п	Examiner		Securetifianty list conditions. ATHERO SCLEROSES											YEAR.	C		
	P #	Iner	dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due lo	(or as consec	quence of):	en venerale e		740					Veno			
	and -trans	Examiner	that initiated events resulting in death) Last	c. 17	4/2	2721	VS.Te	20	90	10			-	YZIK	1		
760,	ate be executed hysicien and he burial-transit	cal E		8	) 45 (J	PTO	541	24	_					Y5A0	7		
687	를 수 역	edic		d	100	1	0107	7/		_			1	0/12			
ŏ	Attending Physician: The law requires thet the death certific in death. • ctor: Atter this certificate has been signed by the attending pl by the funeral director, page 2 should be detached for use as the standard of the second process.	M	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn							23d. C	ate of deliv	ery			
ă	death e atte d for	Physician/M	in the past 12 months? 1 □ Yes 2 □ No	4 ☐ Preg	birth 2 ☐ Feta nant at time of c		□Ectopic pr □ Other (sp		<i>'</i>			N	<i>Aon</i> th	Day Ye	ar		
O.	by the detached	hys	9 ☐ Unknown	9□ Unk	nown			-									
_	es the Igned t	by P	Part II. Other significant condition	ns contributing to	death but not res	sulting in the u	inderlying c	ause giv	en in Part I		23e. Did to	bacco use co		he cause of dea			
Records,	w require been sl	bed	1+4POT7+41	Take	5M						1 <b>S</b> Y	es 2□No	3 ☐ Pro	bably 4 □Uni	known		
ပို့ မင်	elawr hasbe je 2 sh	Completed	CHRANCE	CEMAC	MA	LUR					24a. Was a	sv	prior to co	opsy findings av	railable use of		
	ysician: The is certificate ha director, pege	5	HNEMDA	_	,	•					perfor 1 Yes		death?	2 🗆 No			
/ita	iclan: Th certificate rector, peg	Be	25. Was case referred to medical examiner?	11				T ou		e of Deat	h (Check only or	10)					
<u></u>	Physic this c	은	1 Yes 2 No			ER/Outpatie			4   N	ursing Ho	ome 5 Resid			fy)			
Division of Vital	After After funer	lo I	27. Manner of Death 1 ■ Natural 5 □ Pendin	9	of Injury nth, Day Year)	28b. Time of Injury	M	8c. Injur Wor	yat k? Yes 2. ☐	No	28d. Describe h	ow injury occi	urred				
<u>s</u>	or Attending effer death. Director: Affer in by the funer	cat	2 Accident investig 3 Suicide 6 Could r	ot be	e of Injury - At h	nome farm st			163 2		28f. Location (S	treet and Nun	nher or Ru	al Route Numbe	er.		
≦.		Certification:	4 Homicide determ	buil	ding, etc. (Speci	fy)	root, ractory	, 011100			City or Tow				. ,		
_	To the Hospital or within 24 hours efter To the Funeral Discompletely filled in			g Physician: To th													
	n 24 ł n 24 ł ne Fu	Medical	(Check only 2 Medical one)	Examiner: On the and ma	basis of examination of the state of the sta	ation and/or ir	vestigation	, in my o	pinion, dea	ath occur	red at the time, o	date and place	e, and due	o the cause(s)			
	To the within 2 To the complet	Σ	29b. Signature and title of certifie	1	1.	^	290	. Licens	e number	. /	4	29d. Date sign	ned (Month	Day, Year)			
	^		1 Leur	Kep	- 14.	0	t	1/7	77	/	6	1/2/	120	0/			
	\ 1	_	30. Name and address of person	who completed car	use of death (Ite	m 23a) (Type	Print)			)	, 6			11216	061		
	1		LAND KESE, 17	11-042	724/2	200	17051	17	ALV	gi	2 028	NKU	ZADS	PULLY	CAUS		
	Sta Registi		31. Date filed (Month, Day, Year)		Registrár's Sign	acure .											
	5131		IIIN 2 2	7111/ <b>/2</b>	Carre A		Tell 1										

DHMH 17 Rev 1/2001

ORIGINAL

P.O. Box 68760, Division or Vital Records, HAMBERS, KATE

1000

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Director:

within 24 hours a 12

Medical

State

Registrar

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

61395

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

6/7/07

and manner stated.

Merino-Juarez, Jose G., 10 Center Drive, MSC 1063, Bethesda, MD MD

31. Date filed (Month, Day, Year)

4 Homicide

29a. Certifier (Check only

29b. Signature/a

JUN 2 2 2007 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-04484 State of Maryland / Department of Health and Mental Hygiene Yvonne Century 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day June 11, 2007 2243 hrs **Medical Examiner** IDANE DENISE. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number Baltimore St. Agnes Hospital g. Birthplace (State or 8. Date of Birth (MM/DD/YYYY) If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Days Hours Min. Country) Meery 1-30 for Director 2 F М 1462 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location MORE or 28a-f show items 23a or 28a-f shoust be notified at once. MAYLAND with the Maryland Director 10g. Citizen of What Country 10f. Zin Code 10e, Street and Number USA 212/6 AS H BUTTON 707 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status must be Armed Forces death 1 Never Married 2 Married Yes þ Yes 2 No specify: after Divorced If Yes. Give Year t Pages I and 2 should be filed within 72 hours after timent of Health and Mental Hygiene.
rtant: If Hem 27 is marked other than "natural", y or other traumatic event, the Medical Examiner. þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Baltimore, MD 21215-0036 18.Mother's Name (First, Middle, Maiden Syrname HIE EC Be SON OS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, tate, Zip Code) 19a, Informant's Name/Relationship (Type, Print ) 2/2/5 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 2 Cremation 3 1 X Burial 07 ansdowne. Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Liversee sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a. Part . Enter the **Physician** ure. List only one cause on each line. Death **V** dical a. Lobar Pneumonia Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical UNPENDED AMENDED the attending physician ed for use as the burial e Hospital or Attending Physician: The law requires that the death certificate be 0. 24 hoursalter death.
Funeral Director: After this certificate has been shown. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Fetal death Day Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Yes 2 No 3 Probably 4 ✔ Unknown Hypertensive Cardiovascular Disease; Sarcoidosis Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? 1 🗸 Yes ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? lospital: 1 Inpatient 2 Residence 6 DOA Nursing Home 5 ER/Outpatient 3 No 1 VYes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1 V Natural Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be 3 or Town, State) Suicide (Specify) Homicide

Medical To the 1

29a. Certifier

2 1 29b. Signature and title of certifie

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

32 Registrar's Signature

29c. License number O.C.M.E

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) June 12, 2007

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD

31. Date filed (Month, Day, Year) State Registrar

OCME

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10d per fh 9868 6-22-07 yt. State of Maryland Prepartment of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 🦾 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 200 DEBORAH COHEN 21 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 5. Social Security Number Baltimor N/A If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 05/18/1970 Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 □ F 37 INDIA Director 470-78-5803 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at X No **Funeral Director** BALTIMORE BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3716 MICHELLE WAY 21208 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural"; or ite 1 ☐ Yes 2 【 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) MEDICAL DOCTOR MEDICINE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be COHEN SARAH STEINBERG ပ ABRAHAM 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.3 Department of Health at Important; If item 27 is any injury or other trau 3716 MICHELLE WAY BALTIMORE, MD. 21208 COHEN / FATHER ABRAHAM 20b. Place of Disposition (Name of BETH EL MEMORIAL 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State 06/22/2007 RANDALLSTOWN, MD 4 Donation 5 ☐ Other (Specify) SOL LEVINSON & BROS., INC. 22. Name and Address of Facility of Funeral Service Lice 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or com shock, or heart failure. List only Approximate Interval Between Onset and Death complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (c) as a consequence of) Examiner ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes 2 After this certificate I 25. Was case referred to medical examiner? funeral director, Be ( 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Date of Injury (Month, Day Year) 1 TYes 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death uneral Director: 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral L ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Wedical (Check only one) completely and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific M.D. 30. Name and address of person ho completed cause of death (Item 23a) (Type, Print) Boltimore, 2401 W. Belvabre Ave, Balthurg MARIA 6 MD Similaria y, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last Month **Physician** enee /Medical street and number) 4b. City, Town, or Location of Death 4c (If not institution, give 4a. Facility Name Examiner ha 4 9. Birthplace Country) Date of Birth (Month, Day, Social Security Number 7. Age (In vrs. last birthday) (State or Foreign **Funeral** 1 M 2 F Months Days Hours BALTIMORE MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 23a or 28a-f show ust be notified at 1 Yes 2 XNo Director H 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Injury or other traumatic event, the Medical Examiner must be 609 2101 rai Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) marked other than "natural", or Items 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nsuranco 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumath. 17. Father's Name (First, Middle, Last Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 009 Edinshal 900026 Irail 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State in Christian Centitery 6/21/07 Fallston MO 22. Name and Address of Facility for Ve Forest Hill MD 21050 Evans Funcial Chapel Cremation Services-Beldin 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service Lio ons that caused the reath. Do not enter the mode of dying, such as carriac or respiratory arrest, 23a. Part1. Enter the disease shock, or heart failure. immediate Cause (Final disease or condition resulting in death) 1efastatic Physician Breast cance 20months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the all 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 Tes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy perform certificate 1☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 2 Accident (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 06-19-2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. SIVASAILAM, Suite 200, S. Belain MD 21014 Atwood,

State Registrar

DHIVIH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

UN 2 2 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
PI, line b-c, 25, perils, 8808, 100 (1) 1- For Amend #PI, line b-c, 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Adam James Duncan May 31, 2007 1505 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 219–18–3116 **Funeral** 1√2 M 2□ F Director 81 Jan 6, 1926 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits f show 27 is marked other than "netural", or Items 23a or 28e-f shov treumstic event, the Mudical Examinar must be mutified at 1 Yes 2 No Director MD Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8072 Woodholme Cr 21122 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? ※¾ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: Specify: ۶ 3 Widowed 4 □ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Conductor Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be finent of Health and Mental Finent: If item 27 is marked of Joseph VonTran Martha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) other Glenn Duncan Son 8072 Woodholme Cr, Pasadena, ND 21122 20b. Place of Disposition (Name of cemetery) crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of It t Burial 2 Cremation 3 Removal from State ō ' 4 ☐ Donation 5 ☐ Other (Specify) 11e Vets Cem **Crownsvi** June 5, 2007 Crownsville, MD 22. Name and Address of Facility Fink Funeral Home, P.A. 426 Crain Hwy S., Glen Burnie, MD Gregory (F) К. 23a. Part1. Enter the disease or co shock, or heart lailure. List on cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e cause on each line. Immediate Cause (Final disease or co-cition resulting in death) 011 TOAITIS Pnysician /Medical whe to (or as a consequence of): Dehiscence of ileocolonic anastomosis **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Status post hemicolectomy and hernia negative Examine The law requires that the death certificate be executed burial-transit CERTIFICATION APPROVED BY that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy jo in the past 12 months? Month Day 5 Other (specify) ☐Yes 2☐No P.O. detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ þe 1 Yes 2 No 3 Probably 4 Doknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 5/4 page 2 s has autopsy perform certificate 1 Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 \( \tau \) Nursing Home 5 \( \tau \) Residence 6 \( \tau \) Other (Specify) 1 XYes 2 2 ER/Outpatient 3 DOA this in by the funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After : Certification; 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) determined To the Hospital or A within 24 hours after 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 12408 グーろ1-2007 nd ad ress of person who completed cause of death (Item 23a) (Type, Print) FAME Amapeles Met Peterson MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 0 2007 Registrar

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

7

State Registrar 31. Date filed (Month

Lutherville MD 21093

36. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #18, perffl, C808, 6/26/0/11
State of Maryland / Department of Health and Mental Hygiene

1- State Amend #5,8,18,20b-c, perffl, C808, 6/22/07/11
Reg. No. 17 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician**  $\mathbf{P}^{\mathsf{M}}$ 2007 Maureen Anne Donohue 19, 12:06 June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 809 West Padonia Rd. Baltimore Cockeysville, MD 21030 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yead 1942 Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Director 141 34 <del>8079</del> 65 Mar 21, 2007 N.J. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show or items 23a or 28a-f show 1 ☐ Yes 2 ☑ No Director MD Baltimore Cockeysville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 809 West Padonia Rd. 21030 USA death Completed by Funeral 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Black, White, etc. Examiner Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: white 3 Widowed 4 Divorced Year or Dates: 'natural", the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) f Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Director of Women's Ministries Religious or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John J. Deeney Hellen Joolen 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Michael Donohue Sr./Husband 809 West Padonia Rd. Cockeysville, MD 21030
20a. Method of Disposition | 20b. Place of Disposition (Name of Disposition | Date | 20c. Location - City or Town, State 20a. Method of Disposition Department of h Important: if ite any injury or ot Catonsville, MD 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 22,07 Timonium Bullium Clau permit. 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 West Padonia Rd. Timonium, MD 21093 Inc. 23a. Pa 1. Ent r the disease, or complications to strock, or leart failure. List only one cause at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Imme rate Cau e (Final DAUS **Physician** or con /Medical Due to (or as a consequence of) **Examiner** OB 130 WEZ STRUCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury Due to (or as a consequence of Examiner VARIAN The law requires that the death certificate be executed that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician Physician/Medical the attending p for use as t 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 Other (specify) 4 Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform 1∐ Yes the Hospital or Attending Physician; director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manyler of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes n 24 hours after death. he Funeral Director: A bletely filled in by the fu 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 2 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Lean P. Mi Sure 716801 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RANKLIN SQUARE Dr. BALT, MD M= GUIRE 9103

DHMH 17 Rev 1/2001

State Registrar 32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hydiana

Robert M. Drunsfie	1	State of Maryland / Department of Health and M  For State  Certificate of Death	lental Hygiene	Reg. N	200	7 2020				
Physician	1	edistrar Decedent's Name (First, Middle,Last)	2. Date of I Month	Day	y Year	3. Time of Death 0820 hrs				
Medical Examine		Robert M. Dronsfield  la. Facility Name (if not institution, give street and number)  4b. City, Town, or Local	June 16 ation of Death		4c. County of Death					
	ı	3113 Bellbrook Court Temple Hills	D <sub>0</sub>		Prince George					
Funeral Director		579 88 1123 1 Months Days H			M/DD/YYYY) 9. Birt 4,1962 Foreig Cou					
any	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits				
od show a	_	Maryland Prince George's Temple Hills				1 Yes 2 No				
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiène. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show; Important: To De Compalated by Eunoral Director		10e. Street and Number 10f. Zip Code 20748	3		Citizen of What Cour nited Stat	tes				
t be no	runeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic 14. XX Never Married 2 Married Armed Forces? 13. Was Decedent of Hispanic 15. Karned Forces? 16. Yes, specify Cuban, Mexical Status			14. Race - Ameri White, etc.	can Indian, Black,				
ler dea		1 Yes 2 XX No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 XXNo specific Yes, Give Year	pecify:		Specify: Whi	ite				
ours af		15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation ( during most of working life. DO		161	b. Kind of Business/l	ndustry				
n 72 ho nan "n; ical Ey	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  12 Unemployed	1101 000 101100)		N/A					
-003 d withi	<u></u>	1 7	Nother's Name (First, Mide	dle, Maid	<u> </u>					
215 be file ntal Hy rked o	å	Robert Samuel Dronsfield	Margaret		iemeyer					
MD 21 12 should th and Me 127 is ma To	<u> </u>	19a Informant's Name/Relationship (Type, Print) Robert S. Dronsfield (Father) 19b. Mailing Address (Street and 3113 Bellbrook	Court, Temp	le F	Hills, MD	20748				
nore,   ages l and of Heal of: If item		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition (Name of cemeter crematory or other place)  Resurrection Cemet	une 22, 2007	, I	Oc. Location - City or Clinton, N					
altir mit. F partme portal jury or	ŀ	21. Signature of Funeral Service Intensite 22. Name and Address of F	Facility Lee Fune	eral	Home, Inc	6633 Old				
	4	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such	Ferry Road.	Clir v arrest,	nton, MD 2 shock, or heart	20735 Approximate Interval				
Physician Medical	Į	failure. List only one cause on each line.  Immediate Cause (Final disease a, Diverticulitis with complications  Between Onset and Death  Death								
Examiner	1	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):								
	直	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):								
ed usit	Examine	Co.  (Disease or injury that initiated events resulting in death) Last  Co.  Due to (or as a consequence of):			_					
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60, ate be	ĕ I	UNPENDED X AMENDED #1, perME, g868, 6/22/07 TT  IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliver	-				
Sox 6876( death certificate e attending phys for use as the b	sician/M	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 E	Ectopic pregnancy	I	Month	Day Year				
Box 6876 e death certificate the attending phy ed for use as the?	Physic	1 Yes 2 No 9 Unknown 9 Unknown								
p, P.O. Bc ires that the des signed by the a 1 be detached for	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause giver	n in Part I. 23e.		cco use contribute to 2 ✓ No 3 Pro	the cause of death?				
duires quires and be	te d			Was an	24b. Were a	utopsy findings available				
COrc	Completed			autopsy performe Yes 2	ed? death?	completion of cause of				
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Vita ysician this cer	o Be	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Oth	ner. 4 Nursing Home		esidence 6 🗸 Othe	er: Scene				
n of Vital Records, fing Physician: The law requii After this certificate has been : funeral director, page 2 should	on: T	27. Manner of Death  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at 1 Yes	at Work? 28d. Desi	cribe hov	v injury occurred					
Division of Vital Records, P.O. tal or Attending Physician: The law requires that it is after death.  The law requires that the an increment of the director. After this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office build	ding, etc. 28f. Loca	tion (Stre		Rural Route Number, City				
hou hou		4 Homicide (Specify)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date a	and place, and due to the	cause(s	s) and manner as sta	ated.				
To the within within to comple	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, de and manner stated.  29b. Signature and title of certifier 29c. License no			29d. Date signed (M					
	2	29b. Signature and title of certifier  O.C.M.E		- 1	June 17, 2007					
(0)		30. Name and address of person who completed cause of death (Item 23a)  Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Balti	rimore MD 21201							
Sta	ate	Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Balti  31. Date filed (Month, Day, Year)  32. Registrar's Signature								
Registr		JUN 2 2 2007 Bears & Joseph								
DHMH 17 Rev 1/20	001	ORIGINAL								

8	Phy /M	sic edi
	Exa	ımi
Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed the Holling Approximation of the Hospital of Approximation of the Hospital of	To the Funeral Director: After this certificate has been signed by the attending physician and

		Pleas	se Type or Print in	Blac	k Indelik	ole Ink.	Ensure A	II Copies	Are I	_egible	
		For State	State of Maryla	and / [	•			Mental Hy	giene		
		Registrar			Certifica	ate of	Death	T	Reg. No.	200	7 20206
Physicia	an	Decedent's Name (First, Middle     Dana	Jackson		T Janour J	_		2. Date of De Month	Day		
/Medic		4a. Facility Name (If not institution			Edward		r Location of Death	June 5,		County of De	1:22 A M
Examin	er		ventist Hospita	1		koma				ontgo	
Funeral		5. Social Security Number	6. Sex 7. Age (In )	rs. last bir	thday) If Un	der 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth av. Year)	9. E	irthplace (State or Foreign Country)
Director		439-23-9838	1□M 2ŒF 32		Yrs.	lo Bujo		Sept. 3	3, 19	74 Lo	uisiana
fand ow		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Tow	n or Location						10d. Inside City Limits
Mary Ff sh	tor	Maryland Princ	ce George's	Hvat	tsvill	e					1 MYes 2 No
th the or 28s e noti	)irec	10e. Street and Number				Zip Code			10g. Citiz	zen of What	Country?
filed within 72 hours after death with the Maryland Hygiene. Hygiene, than "natural", or Items 23a or 28a-f show ther than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral Director	6207 43rd Avenu				20781			U.S		
er dez items ner m	nne	11. Marital Status	12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 ▼ No	n U.S.	13. Was De If Yes, s	ecedent of H specify Cub	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No o Rican, etc.)	)-	14. Race - Ar Black, W	nerican Indian, nite, etc.
irs aft	by F	1 ☐ Never Married		1 ☐ Yes 2 No Specify:					Specify: P	lack	
2 hou latura	ted	15. Decedent	t's Education	16a	. Decedent's L	Isual Occup	pation	4.7	16b. Kir	nd of Busines	s/Industry
thin 7	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NO	Work done Tuse retire	during most of word d)	KING			
led wi lygier her th	Co	47 Fallenda Nama / First 1 didulla	4	R	leporte	r	10. Machine de Name	- /Fina Baidati			nication
t be find the other of the other of the other of the other o	Be	17. Father's Name (First, Middle, Freddie L. Jac	,				18. Mother's Nam			Surname)	
should bd Me mark mark	ပ	19a. Informant's Name/Relationsl		19b	. Mailing Addr	ess (Street	and Number or Ru	lae Mars		r Town. State	. Zip Code)
nd 2 salth ar		Julien Edwards (	(Husband)		_		Rd. #204				
of Hear		20a. Method of Disposition	20	b. Place o	f Disposition (i	Name of or other place	ce)	Date	20c. Lo	cation - City	or Town, State
Page ment ant: If uny o		1 ☑ Buriel 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 [ I tellioval from State	t. 01			6/15	/07	New	Orlea	ns, LA
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Maral Hygiene. Important: If time 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Licensee		22 Name Char	and Addre	ss of Facility t Labat F	uneral	Home		
20580		23a. Part1. Enter the disease, or	Outlow	Lastin Da			Philip St			ans, L	A 70116 Approximate
		shock, or heart failure. List Immediate Cause (Final	t only one cause on each line.	leath. Do	not enter the r	noue or ayır	ng, such as cardiac	or respiratory a	arrest,		Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Diabetic K			S			_		0
Examiner			b. Right Uppe:		,						
X 6	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con								
be executed cian and ourial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	С								
be excian a	_	rosuming in dodary East	Due to (or as a con	sequence	01):						
The law requires that the death certificate by the has been signed by the attending physic bage 2 should be detached for use as the bu	Physiclan/Medica		d								
n certii inding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pre		- 🗆 -				2	23d. Date of	delivery
death e atte	icla	in the past 12 months? 1 ☑ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time		n 3 ∐Ectopi 5   Other	c pregnanc (specify) _	у			Month	Day Year
at the by th	hys	9 Unknown	9∐Unknown								
res th	þ	Part II. Other significant condition Renal Failure	ons contributing to death but not	resulting i	n the underlyir	ng cause giv	en in Part I.		tobacco u		to the cause of death?
requi	Completed										Probably 4 ☐Unknown
e la has	mple	Leukocytosis							s an opsy formed?	24b. Were prior death	autopsy findings available to completion of cause of
		25. Was case referred to medical	1				00 81 (8	1□ Yes	2X No	1 🗆 Y	es 2 No
Attending Physician: r death. ector: After this certifice by the funeral director, p	To Be	examiner?	Hospital:		utpatient 3	DOA Oth	26. Place of Dea	ith (Check only Iome 5 ☐ Res		6 ∏Other /S	necify)
ng Phr ter thi		27. Manner of Death	28a. Date of Injury	28b.	Time of Injury	28c. Inju Wo		28d. Describe			, , , , , , , , , , , , , , , , , , ,
endin ath. or: Af he fur	Certification:	1 Natural 5 Pendin 2 Accident investig	gation	.,	M		Yes 2 □ No				
or Att ter de jirect n by t	rtific	3 Suicide 6 Could i 4 Homicide determ		At home, fa ec <i>ify)</i>	arm, street, fac	ctory, office		28f. Location City or To	(Street an own, State	d Number or )	Rural Route Number,
pitai ours ai		29a. Certifier 1 Certifyir	ng Physician: To the best of my	knowleda	e death occur	red at the ti	imo, data and place	and due to the	2 22122/2	and	an etated
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only 2 Medical one)	Examiner: On the basis of examiner stated.	mination a	nd/or investiga	ition, in my	opinion, death occu	urred at the time	e, date and	d place, and	as stated. fue to the cause(s)
To the To the To the Somple	Me	29b. Signature and title of certifie	er .			29c. Licens	se number		29d. Dat	te signed (Mo	onth, Day, Year)
/		MITE	M.D			05	9121		61	5/20	07
5		30. Name and address of person	who completed cause of death (							J/ 0	
		Tasneem Malik,			Ave.,	Takon	a Park, l	MD			
Sta Registi		31. Date filed (Month, Day, Year)	007 Asia J	A C	parte						

Division or Vital Records, P.O. Box 68760, A	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certification: To Be Completed by Physician/Medical Examin
	\	
DH	St Regist	ate trar 2001

		For State Registrar	State of Marylan		ertificate of L			eg. No.	7 20207		
Physicia	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year  MERRIL BETH EPSTEIN  2. Date of Death Month Day Year  JUNE 12, 2007  6:4										
/Medic		MERRIL BETH	2007	6:46P M							
Examin	er	4a. Facility Name (If not institution, give stre	4c. County of I								
		HOWARD COUNTY GENER	HOWARD	Birthplace (State or Foreign							
uneral irector								Year)	Country) MEW YORK		
» ta		Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location									
a-f sh filed	ţċ	MARYLAND HOWARD	EI	LICOT	T CITY				1 ŽiYes 2 ☐ No		
r 28e notl	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wha	at Country?		
23a o ist be		3680 MOUNT IDA DRIVI	E #B		21043			U.S.A.			
ems er mu	Funeral	11. Marital Status	. Was Decedent Ever in U Armed Forces?	.S. 13	B. Was Decedent of His If Yes, specify Cuba	spanic Origin? (Spe n. Mexican, Puerto	ecity Yes or No- Rican, etc.)		American Indian, White, etc.		
Department of Heatin and Mentiar Hygene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumante event, the Medical Examiner must be notified at once. Once.	by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No Specify:			, , , , , , ,	Specify:			
'natu dical	etec	15. Decedent's Educat (Specify only highest grade c	tion completed)	16a. Dec	cedent's Usual Occupa ve kind of work done d . DO NOT use retired,	ation Juring most of worki	ng I	16b. Kind of Busin	ness/Industry		
than than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	1	OMEMAKER	)		OWN HO	ME		
ther ent, the		17. Father's Name (First, Middle, Last)		1		18. Mother's Name	(First, Middle, N				
ked o	To Be	LIONEL KIRSHNER				LILA MA	DOW				
mar umat	-	19a. Informant's Name/Relationship (Type	. Print)	19b. Ma	iling Address (Street a			; City or Town, Sta	ate, Zip Code)		
aith a 27 Is 27 Is er trai		LISA EPSTEIN (DAUG	HTER)	3521	FRONT ST.	, SAN DIE	GO, CA	92103			
or He Fitem rothe		20a. Method of Disposition		Place of Dis	position (Name of rematory or other place		Date	20c. Location - Cit	ty or Town, State		
ant: If		1 M Burial 2 Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	HILLS, CA								
Imports any inj		21. Signature of Funeral Service Licensee	Min		22 Name and Addres CHEVRA KAD 7832 SANTA			OS ANGEL	ES, CA 90046		
ysician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.									
Medical aminer		Sequentially list conditions b									
t tio	iner	if any, leading to immediate  Cause. Enter Underlying  Cause (Disease or injury									
and I-trans	Examine	Cause (Disease or injury that initiated events c.  The provided in the provide									
physician and s the burial-transit											
phys s the	edical	d									
within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use at	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes No 9 ☐ Unknown	of delivery n Day Year								
en signed build be deta	by	Part II Other significant conditions contri	ute to the cause of death?  Probably 4 Unknown								
ate has bei page 2 sho	Completed						24a. Was a autops perform	y prio med? dea	ere autopsy findings available or to completion of cause of ath?  Yes 2 \( \) No		
ertific ector,	Be (	25. Was case referred to medical examiner?	W-14-1		Tail	26. Place of Death	(Check only on	e)			
this c al dire	ဍ	1 163 2 110	spital: 1 Inpatient 2			4 LI Nursing Ho		ence 6 Other	* * * * * * * * * * * * * * * * * * * *		
After funera	ion:	27. Manner of Death  1   Natural 5 □ Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injury	y Work	/ at <br Yes 2 □ No	28d. Describe ho	ow injury occurred			
after death  Director:  In by the	ertification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, s fy)			28f. Location (St City or Town		or Rural Route Number,		
e Funeral	edical C		cian: To the best of my known: On the basis of examinating and manner stated.								
To the comp	Me	29b. Signature and title of certifier	Treelme	in D	29c. License	90211	2	9d. Date signed (	Month, Day, Year)		
\		30. Name and address of person who com	pleted cause of death (Iter	n 23a) (Typ	260 F	t, (OL	UMBIA	MO	21045		
Sta Registi		31. Date filed (Month, Day, Year) JUN 2 2 2007	32 Registrar's Sign	ature	arti		-	/			

07-04697 Ellen Eberly

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

llen Eberly	1- For State	of Maryland / Dep Ce	artment of		d Mental Hy	ygiene Reg.	No. 200	7 20200
Physician/	1. Decedent's Name (First, Middle,La	st)				2. Date of Death		3. Time of Death 1843 hrs
Medical Examiner	Ellen Eberly June 19, 2007							
	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County  Baltimore Washington Medical Center  Glen Burnie  Anne A							l l
Funeral	5 Social Security Number 6. S	ex 7. Age (In yrs	. last birthday)	If Under 1 Year		-		rthplace (State or
Director	<del>151</del> -26-3408	M 2 XF	72 Yrs	Months Days	Hours Min.	09/26/	1934 Forei	ennsylvania
·	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Locati	on				10d. Inside City Limits
- Ic w	MD Anne Ar	rundel 0	rchard	Beach				1 Yes 2 XNo
Maryland 28a-f show any d.at once. ector	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cou	intry?
the Maryland a or 28a-f sh tified at once Director	616 Water View I	rive		21226		13	nited Stat	es
death with the Maryland or items 23a or 28a-f she must be notified at once Funeral Director		12. Was Decedent Ever in		s Decedent of His	panic Origin? ( Sp	ecify Yes or No-		rican Indian, Black,
r death with or items 23 must be no	1 Never Married 2 Marrie	d Armed Forces?  1 Yes 2 X No		es, specify Cuban		Rican, etc.)		
s after rall, o	3 Widowed 4 A Divorce	d If Yes, Give Year or Dates:		Yes 2X No			Specify: WI 6b. Kind of Business	nite
hours hours Exam		College (1-4 or 5+)		it's Usual Occupati ost of working life.			ob. Kind of Business	industry
36 nin 72 E. than 'dical	Elementary/Secondary (0-12)	2		Nurse			Health	Care
e, MD 21215-0036  I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho r traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	17. Father's Name (First, Middle, Las			1	18.Mother's Name	(First, Middle, Ma	niden Surname)	
218 be fill mtal H rked rked emt, t	Joseph Wentz	<b>Z</b> 		6.3160=1==================================		Keen		
nore, MD 2121 agges 1 and 2 should be fi nt of Health and Mental 1: If item 27 is marked other traumatic event, To Be		•	- 1				er, City or Town, Stat	
MD and 2 sho salth and em 27 is raumati	Kay Florey, Daug			ater Vie			Beach, MI 20c, Location - City of	
<b>≥</b> ∞ 4 = ≥	1 Burial 2 Cremation 3	XRemoval from State	crematory or ot	her place)		22/2007	Nescopeck,	T) X
다 캠 등 는 <b>그</b> .	4 Donation 5 Other Special Lice	у.		neral Ho			neral Serv	
Balt permit Depart Import injury	THE OF THE	MOTT					Burnie, N	
Physician	23a. Part I. Enter the disease, or con		ath. Do not enter t	he mode of dying,	such as cardiac o	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	failure. List only one cause on Immediate Cause (Final disease	a. Soot inhalation comp	licated by ath	erosclerotic c	ardiovascular	disease		Death
.xammer	or condition resulting in death)	Due to (or as a consequence	e of):					
70	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	e of):					
- i	cause. Enter Underlying Cause (Disease or injury that initiated	c						
red Insit	events resulting in death) Last	Due to (or as a consequence						
(0, e be executed ysician and burial - transit	UNPENDED	x AMENDE 7,5 per	fh g869	<del>7-23-07</del>	VL			
60, ate be ohysici ne buri		23c. If yes, outcome of pr					23d. Date of delive	ry
687 ertific ding r e as th	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at time of	etal death 3	ancy	Day Year			
b. Box 6876, the death certificate by the attending phy locked for use as the Physician/M	1 Yes 2 V No 9 Unknow		5 0	ther (Specify)				
O. E at the c Iby th		s contributing to death but no	ot resulting in the	underlying cause (	given in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
, P.C						1 Yes	2 No 3 Pr	obably 4 🗹 Unknown
rds v requi						24a. Was a autops	y prior to	autopsy findings available completion of cause of
Records,   The law requires fricate has been significate by a significate by a significate by a significate by the significant between the significant				<del></del>		perform 1 Yes 2		Yes 2 No
tal Rician: T				26.Place	e of Death (Check	only one)		
F Vit. Physici or this c	1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatien			•	Residence 6 Oth	er:
Division of Vital Records, P.O. tall or attending Physician: The law requires that the star death  "I Director: After this certificate has been signed by lied in by the funeral director, page 2 should be deach partification: To Be Completed by P.		28a. Date of Injury (Month, Day, Year) FOUND:	28b. Time of UNKNOW!		ıry at Work? Yes 2 ✔ No	Accidental h	ow injury occurred ouse fire	
Sior Attend death death sector:	2 Accident S Pending Investig	1 1 40 0007				28f Location (S	reet and Number or F	Rural Route Number, City
Division o spital or Attending hours after death neral Director: After filled in by the fune	3 Suicide 6 Could n	ot be		ot, factory, office i	bullating, otc.		ate) Drive, Curtis Bay,	
Lospit 4 hour quner;		ician: To the best of my know		rred at the time, d	ate and place, an	1		
Division of Vital Records, P.O. Box 68761 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the bearded for the funeral Certification: To Be Completed by Physician/Mi	(Check only one) 2 Medical Examin	ner: On the basis of examination and manner stated.	n and/or investiga	ation, in my opinior	n, death occurred	at the time, date a	nd place, and due to	the cause(s)
F % F % B	29b Signature and title of certifier	0.00	0	29c. Licens			29d. Date signed (N	fonth, Day, Year)
	tatulen	- tolle	r m	O.C.	M.E. 		June 20, 2007	
3	30. Name and address of person when Patricia Aronica-Pollak N			111 Penn S	treet, Baltimo	re, MD 21201		
Stat		32. Registrar's Sign	nature	of 9				
Registra	ar JUN 2 2 20	07 Stephen So	1º AMPAINE	Sec.				

			For State Registrar	State of Ma	aryland /		rtment of He tificate of D			giene () ()	7 20209	
	Physicia	_	Decedent's Name (First, Middle, Charles	Last)	Earley	v			2. Date of Dea Month June 1	Day Y	ear 3. Time of Death 10:59AM	
	/Medic Examin	_	4a. Fecility Name (If not institution, Fort Washin				4b. City, Town, or Fort Wa	Location of Dealh shington	Julie 1	4c. County of		
	Funeral Director				ge (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month Da OCT 16	y, Year) 20	Birthplace (State or Foreign Country) h10	
	yland how		Usual Residence of Decedent  10a. State 10b. County	_	10c. City, T						10d. Inside City Limits	
	he Ma	Funeral Director	Maryland   Prince	George's	Car	mp Sp	rings			10g. Citizen of Wh		
	3a or 3	20	6303 Joyce I	rive			20748	}		United S		
	ems 2	nera	11. Marital Slajus	12. Was Deceden! Armed Forces?		13. V	Vas Decedent of His Yes, specify Cubar		ecify Yes or No Rican, etc.)	14. Race - Black,	American Indian, White, etc.	
920	within 72 hours after death with the Maryland ene. than "naturel", or items 23e or 28e-f ehow ha Marical Exeminar must be notillian at	þ	1 ☐ Never Married	od 1 TYes 2 1 If Yes, Give Year or Dates:	No WWII	ł	☐ Yes 2☐ No	Specify:		Specify:	White	
5-0	"natu	ietec	15. Decedent' (Specify only highest		1	(Give	ent's Usual Occupa kind of work done di OO NOT use retired)	uring most of work	ing	16b. Kind of Busi	ness/Industry	
21215-0036	d within	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	Retir				US Civil	Service	
Maryland 3	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel; or items 23a or 28e-f show any injury or other traumatic event, the Marical Exaculate count be notified at once.	To Be C	17. Father's Name (First, Middle, L Ottis Earl						e (First, Middle, 11iamsc	Maiden Sumame) )N		
Mary	alth and N		19a. Informant's Name/Relationsh Ruth C. Earley		1	19b. Mailin 6303	g Address <i>(Street a</i> Joyce Dri	nd Number or Run Lve, Camp	al Route Number Spring	er, City or Town, St SS, MD 20	ate, <i>Zip C</i> ode) ) 748	
Baltimore,	ages 1 a ant of Hea nt: if item y or othe		20a, Method of Disposition  1 Burial 2 Toremation  4 Donation 5 Other (Sp		ceme	etery, cren	sition (Name of natory or other place natory June	)	Date )7	20c. Location - Ci		
Baltir	permit. P Departme Importan any injur		21. Signature of Funeral Service L			22		of FacilityLee	Funeral	L Home,In	c 6633 01d	
			23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that caused	d the death. [	Do not ente					Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ a	a consequen						Onset and Death	
ı	Examiner	_	Sequentially list conditions,	P~	EUMO,	NIA						
J.	ransit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				INSUFFIC	LENCY				
8760,	te be exec ysician ar e burial-tr	Ical Exa	cal Exa	resulting in death) Last	c. RESPIRATORY INSUFFICIENCY Due to (or a a consequence of):  CARDIUMYOFATHY							
P.O. Box 68	law requires that the death certificate be executed as been signed by the ettending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: N/A 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant a	of pregnancy 2 Fetal de	/ path 3□		//A		23d. Date Monti		
	uires that the signed by ald be detacted	þ	Part II. Dther significant conditio	E HEART 1	SAILUR		nderlying cause give	n in Part I.	23e. Did t		ute to the cause of death?	
Division of Vital Records,	0 5 0	Completed	SACRAL	PECUBIT					24a. Was auto perfo	psy pri omed? de	ore autopsy findings available of to completion of cause of ath?  Yes 2 \[ \] No	
'ital		BeC	25. Was case referred to medical examiner?					26. Place of Deat		73	7.00 2.0.10	
<b>€</b>	d w	ို	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 A npati		Outpatien b. Time of		4   Nulsing He		dence 6 Olher		
ion	ding After fune	ation	1 Natural 5 Pending 2 Accident investig		ay Year)	Injury	28c. Injury Work M 1 □ Y	? ′es 2 □No		,.,		
Divis	N or Atter after des Directo d in by th	Certification;	3 Suicide 6 Could n 4 Homicide determi	ned 286. Place of in	jury - At home tc. (Specify)	e, farm, sir	eet, factory, office		28f. Location ( City or To	Street and Number wn, State)	or Rural Route Number,	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After thi completely filled in by the funeral	Medicai C	29a. Certifier (Check only one)  Certifying 2 Medical E	g Physician: To the best Examiner: On the basis of and manner st	of examination	edge, death n and/or inv	occurred at the time restigation, in my op	e, date and place, inion, death occur	and due to the red at the time,	cause(s) and mani date and place, an	ner as stated. d due to the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and title of certifier				29c. License	1182_		29d. Date signed (	Month, Day, Year)	
	4+1		30. Name and address of person of FELTUN AND	who completed cause of	death (Item 23	9400	Print) Livingst	in Rd #	350 F	T- WASHIN	Month, Day, Year) Lo/07 20744 CTW/MD	
d,	Sta Registr		31. Date filed (Month, Day, Year)  JUN 2 2	EV.	rar's Signature	e Ada	artes					

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / Department of Health and M  1- For Registrar  Amend Item 21 per dvr, g868.06/22/07dbb  Certificate of Death		-	
	Physici		1. Decedent's Name (First, Middle, Last)  I I ZARFTH EMERY	2. Date of Death Month	Day Year 3. Time of Death	
	/Medic Examin		A. C. 10 March 1 of the State of Court and Cou	4b. City, Town, or Location of Death  COLIMBRA		
	Funeral Director		5. Social Security Number  6. Sex 1 Months Days Hours Min.  7. Age (In yrs. last birthday) Yrs.  1 Security Number 155-36-4094  Usual Residence of Decedent	8. Date of Birth (Month, Day, Y 08/26/19)	9. Birthplace (State or Foreign Country)  PA	
	Maryland -f ehow	tor	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 <b>X</b> Yes 2 □ No	
	or 28e	Director	10e. Street and Number 10f. Zip Code	10g	, Citizen of What Country?	
	eath v			acity Yes or No-	USA 14. Race - American Indian,	
920	hours after death with the Maryland turet', or iteme 23a or 28e-f ehow et Examiner must be notified at	by Funeral	If Yes, Give 1 ☐ Yes 2 ★ No Specify: Year or Dates:	Rican, etc.)	Black, White, etc.  Specify: White	
Maryland 21215-0036	hin 72 in "nel	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	ing 16	b. Kind of Business/Industry	
121	TO 15 15 15 15			(First Middle Ma	Own home	
yland	id be ental ked c	To Be	T		Yarman	
Mar	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rura  Howard County General Hospital		Constitution Const	
Baltimore, I	of Healt of Healt if item 2 or other		2/22 Cedat Dark: Columb	pate 20	IC. Location - City or Town, State	
Balt	permit. Pag Department Important: eny injury o		21. Signature of Funeral Service Licensee per DVR Ronald S. Wade, Director 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201	, 655 W.	Baltimore St.	
	Physician /Medical Examiner	, i	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Sequentially list conditions.  If any leading to immediate		Approximate Interval Between Onset and Death	
68760,	The law requires thet the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the buriat-transit.	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C. DEHYDRATION  Due to (or as a consequence of):  H. L. L. L. L. L. L. L. L. L. L. L. L. L.		DAYS.	
P.O. Box (	thet the death certificate led by the attending physi detached for use as the l	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Year	
rds, F	w requires the been signed should be del			23e. Did toba	cco use contribute to the cause of death?  2 No 3 Probably 4 Unknown	
Division of Vital Records,	: The law receive has be page 2 sho	Completed by	WITH ILEOSTOMY	24a. Was an autopsy performe 1 🗆 Yes 2	24b. Were autopsy findings available prior to completion of cause of death?  No 1 Yes 2 No	
V Ita	sician: T certifical rector, p	Be	a examiner?			
10	g Phys er this ieral di	n: To	1 Inpatient 2 Et/Outpatient 3 DOA 4 Nursing Hor	me 5∐ Residen 28d. Describe how	ce 6 Other (Specify) injury occurred	
sion	endin sath. or: Aft he fun	atio	Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No			
Divis	s efter designation is setter designation in the set in	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)	
	To the Hospitel or Attending Physician: within 24 hours efter death.  To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical		and due to the cau ed at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)	
)	To t To t	Σ	29b. Signature and title of certifier  29c. License number  29c. License number	7	Date signed (Month, Pay, Year)	
				len 6 si	ne, #408	
	Sta	ite	31 Date filed (Month Day Year) 32 Registrar's Signature	+u11) 11gl	7, , , , , , , , , , , , , , , , , , ,	
	Registr		LOUT AMERICAN STA			
DH	IMH 17 Rev 1/2	001	11			

ORIGINAL

			For State Registrar	State of Maryland		rtment of H tificate of t			ene 0 0 7	20211
	Physicia		Decedent's Name (First, Middle, Last)	Frank	-		i	2. Date of Death	Pay Year	3. Time of Death
)	/Medic Examin		4a. Facility Name (If not institution, give st			• • • • • • • • • • • • • • • • • • • •	r Location of Death	· · · · · · · · · · · · · · · · · · ·	4c. County of Dea	ath
	Funeral		NORTHWEST HOSPI  5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8 Date of Birth	9 8	rthplace (State or Foreign
	Director		225-52-1608 1 Usuaf Residence of Decedent	M 2 XF 68	Yrs.	Month's Days	Tiours ivial.	9/13/	1938 V	IRGINIA
	aryland ehow	2	10a. State 10b. County MD BALTIMO	1	Town or Loc NDSOE	eation R MILL				10d. Inside City Limits 1 ☐ Yes 2 💢 No
	th the Nor 28a-f	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	Country?
	ne 23a	Funeral D	18 LIBERTY PLA	2. Was Decedent Ever in U.S.	13. V	212 Vas Decedent of H	lispanic Origin? (Sp	ecify Yes or No-	USA 14. Race - Arr	
36	hours after death with the Maryland turel: or Iteme 23a or 28a-f ehow al Examiner must be notified at	by Fun	1 Never Married XXMarried 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1	Yes, specify Cuba	an, Mexican, Puerto Specify:	Hican, etc.)	Specify: B	
2-00	72 hour naturel		15. Decedent's Educ (Specify only highest grade	ation	(Give I	ent's Usual Occup	during most of work		6b. Kind of Busines	s/Industry
2121	d within 72 jene. r then "nai	Completed	Efementary/Secondary (0-12)	Coflege (1-4or 5+)		RSE (LP			MEDICA	L
and	2 should be filed within 72 hours after deeth with the Marylan and Mental Hygiene.  and Mental Hygiene.  and second the resture!, or liteme 23a or 28a-f show an arked other then "naturel!, or liteme 23a or 28a-f show aumatic event, the Madical Examinar must be notified at	Be	17. Father's Name (First, Middle, Last) SAMUEL RICHARD	SON			-	e (First, Middle, M IA MAY 2	fa <i>iden Sum</i> ame) ANDERSON	
Maryland 21215-003		ပ္	19a. Informant's Name/Relationship (Type PAUL R. FRANK /	e, Print) HUSBAND					City or Town, State,	
ď	is 1 and of Health item 27 other to		20a. Method of Disposition	20b. Plac	ce of Dispos	sition (Name of	ce)	Date 2	20c. Location - City of	r Town, State
altimore,	permit. Pages Department of I Importent: If ite eny Injury or of once.		1X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Figneral Service License	EVE		EN CEME	TERY 6/2			HOME 21207
Ba	Depa Depa Impo		1 When a	O. Nowres	4	600 LI	BERTY HE	IGHTS A	VE, BAL	TIMORE, MD
			23a. Park Enter the disease, or complice shock or heart ailure. List only one immediate Cause (Final	e cause on each fine.	1	er the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
1	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):							
		ner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a nonsequa	nes of):					
	xecuted and al-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ince of):					10
8760,	cate be executed bhysicien and the burial-transit	dicai	<b>U</b> d.							
Box 6	eath certific attending p	an/Me	23b. was decedent pregnant	3c. If yes, outcome of pregnand		Ectopic pregnanc	v		23d. Date of d	elivery Day Year
P.O. B	that the deal	Physician/Me	in the past 12 pronths? 1 Yes 2 No 9 Unknown	4☐Pregnant at time of dea 9☐ Unknown	ith 5□	Other (specify)			Worter	Duy Tour
	uires that n signed b	۵	Part II. Other significant conditions con	tributing to death but not result	ting in the ur	nderlying cause giv	ven in Part I.	1		to the cause of death?  Probably 4 Unknown
Division of Vital Records,	The law re, urres that the death certificate be executed as a been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Completed						24a. Was ar autops perform 1 Yes 2	ned? death	autopsy findings available o completion of cause of
Vital	Physicien: ' r this certifice ral director, p	Be	25. Was case referred to medical examiner?	ospital:		Ott	200	th Check only on	e)	
n of	ng Phys fter this meral dir	on; To	1 ☐ Yes 2 ☐ No  27. Manner of Death 1 ☐ Natural 5 ☐ Pending	Impatient 2LE	R/Outpatien 28b. Time of Injury	28c. Inju	ry at rk?		once 6 □Other (S) ow injury occurred	pecify)
visio	To the Hospital or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate completely filled in by the funeral director, pagi	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, str		Yes 2□No	28f. Location (St City or Town	reet and Number or n, State)	Rural Route Number,
ō	spitel or A nours efter neral Direc filled in by		29a. Certifier Certifying Phys	ician: To the best of my know						
	To the Hospitel of within 24 hours of To the Funeral D completely filled in	Medical	(Check only	ner: On the basis of examination and manner stated.	on and/or in	vestigation, in my			ate and place, and d 9d. Date signed (Mo	
	T X T Q		They Then P	hom (1)		0	177 -1		6/161	107
	(		30. Name and address of person who co	mpleted cause of death (Item)	23a) (Type,	Print) Hosp	itel G	nter	fundal	(spin Mb)
	St: Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ле Долд	de la companya dela companya dela companya dela companya de la companya de la companya de la companya dela companya de la companya de la companya de la companya dela compan				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** Wilfred Lee Fuller 20 2007 /Medical 06 6:30 AM 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1213 Watervale Road Fallston, Maryla
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Maryland Harford Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 XM 2 ☐ F Director 215-12-4923 87 04/29/1920 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene.
Item 27 ie marked other then "neture!", or iteme 23e or 28e-f show other traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2X No Director MD Harford Fallston 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1213 Watervale Road U.S.A. 21047 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Trucking Industry Truck Driver 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ပ Dent Fuller Wilhelmina Eichler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (wife) Anne Marie Fuller 1213 Watervale Road Fallston, Maryland 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Peges 1 permit. Peges
Department of
Important: If its
any nlury or of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 4 □ Donation 5 □ Other (Specify) 06/22/2007 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. A 11750 Belair Road - Kingsville, Maryland 21087 assaln 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final androm **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine inding physicien and use as the burial-transit Due to (or as a consequence of) Box 68760, The law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ò Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. the ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 10 wests 3 ☐ Probably 4 ☑ Unknown 1 Tyes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospitel or Attending Physicien: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ W6 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification; 1 Natural 5 Pending To the Hospitel or Attendir within 24 hours efter death. To the Funerel Director: Al 1 □Yes 2 □No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1 Defitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature Mendew . 16444 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Belay MD

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Registrar

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32. Registrar's Signature

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VIJAY-S. NAIR MID

JUN 2 2 2007

31. Date filed (Month, Day, Year)

S. Atwood Ro

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend tate of Maryland / Separtifier of Treating and Mental Hygiene 1 - State Registre Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 539/am ASBURY 6089 6 21 2007 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Franklin Woods Rosedale Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Adopths Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 XM 2□ F 213-22-8351 78 Yrs. 7/4/1928 Maryland Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Baltimore 1 Yes 2000 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 44 Jumpers Circle 21236 USA 12. Was Decedent Ever in U.S. Armed Forces? ★ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 X No white Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) salesman automobiles 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Henry Strayer Edna Riley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44 Jumpers Circle Baltimore, MD 21236 Evelyn Gordy/ wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 23. Evalis Fulleral 1 Burial 200 remation 3 Removal from State 2007 Forest Hill, MD \* 4 ☐ Donation 5 ☐ Other (Specify) Chapel- Bel Air 21. Signature & Funeral Service Licensee 8800 Harford Rd. Parkville, MD<sub>21234</sub> Evans Funeral Chapel & Cremation Services 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final END-STAGE disease or condition resulting in death) Due to (or as a consequence of) SMOKIN Sequentially list conditions, if any, leading to immediate cause. Enter the string Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy rmed 2 Z 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 🔀 No Hospital: Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

29c. License number

D40008

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other than any injury or other traumatic event. It is Me. DUCe. Physician /Medical Examiner The law requires that the death certificate be executed the attending physician and Division of Vital Records, P.O. Box 68760, as the signed by been Hospital or Attending Physicien: After death. after death Director: filled in by the within 24 hours a To the Funerel C To the

Physician

/Medical

Examiner

**Funeral** 

Director

, or Items 23a or 28a-f show

"natural".

death

filed within 72 hours after

the Medical Examiner must be notified at

Director

Funerai

ģ

Be Completed

Examiner

Completed by Physician/Medical

Be

Medicai Certification: To

(Check only one)

29b. Signature and title of certified

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

PARSHALL

30. Na and address of person who completed cause o eath (Item 23a) (Type, Print)



9105

07-04459

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Barbara Griffin State of Maryland / Department of Health and Mental Hygiene UNK UNK Certificate of Death 2. Date of Death Physician/ 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Month Day June 11, 2007 Year 0608 hrs **Medical Examiner** BARBARA BERNICE GRIFFIN 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 220 North Bentalou Street Baltimore City 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** oreiar Months Days Director Hours Country) NV M 2 X F JUNE 12 1988 530-35-4805 18 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3027 E. MONUMENT Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married Married 2 X No Yes 10 Specify: BLACK If Yes, Give Year 3 Widowed 4 Divorced 1 Yes 2 X No specify: "natural" à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Medica HIGH SCHOOL STUDENT 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) 2121 Be BEVERLY BOONE FREDERICK JEFFERSON ۵ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is n r traumatic 2 MONUMENT ST., BALTIMORE, MD 21205 BEVERLY MILLER/MOTHER 3027 E. 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 7201 GERMAN HILL RD. crematory or other place) 1 X Burial 2 Cremation 3 Removal from State portant: ury or oth permit Page Department SACRED HEART of JESUS |06/19/2007 |DUNDALK, MD Donation 15 Other Specify 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, MD he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva **Physician** failure. List only one as se on each line. Between Onset and /Medical Death a Multiple Gunshot Wounds Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transi The law requires that the death certificate be executed Physician/Medical physician a AMENDED UNPENDED Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery Was decedent pregnant in the 3 Ectopic pregnancy Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 ✔ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. O Completed by σ. 1 Yes 2 V No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of this certificate has death? performed? ✓ Yes ✔ Yes 2 No To the Hospital or Attending Physician: 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Hospital: 1 Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 1 V Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) FOUND: After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Subject shot FOUND: Natural 1 Yes 2 V No within 24 hours after death

To the Funeral Director;
completely filled in by the f Pending Jun 11, 2007 0600 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 220 North Bentalou Street, Baltimore City, Md (Specify) Local Street 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 11, 2007 Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Laron Locke MD. 111 Penn Street, Baltimore, MD 21201

Registrar

State

DHMH 17 Rev 1/2001 **OCME 2006** 

31. Date filed (Month, Day, Year)

9 0

32. Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 1010AM GORDON RICHARD 20 2007 JUN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore Cuts The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec 3, 194 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 ☐ F Months Hours 60 Maryland 214-44-3675 1946 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🙀 No Director Horse Shoe Henderson North Carolina 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with thygiene.

Hygiene "natural", or items 23a or 3 31 Amber Drive 28742 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: VietN 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Baltimore, Maryland 21215-0036 Specify. 3 White 3 ☐ Widowed 4 X Divorced VietNam Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pepco Instrument Technician 12 and Mental Hygie is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Emma Marie Domeika Rollow Gordon Frank 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau 2607 Ardmore, Royal Oak, Mi. 48073 Richard A. Gordon, Jr. (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐Removal from State Bayview Crematory, Inc. 6/21/07 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Kevin E Ecker McCully-Polyniak Funeral Home, P.A. 237 F. Patapsco Ave., Balto., Md. 21225-1856 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) week **Physician** Pheumon /Medical Due to (or as a consequence of): Examiner week IZUYE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Examir burial-tran and Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 No 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknow signed by t 1 be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ≥ 1 🔲 Yes 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1∏ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 DOA 1 Inpatient 1 Yes Certification: To 27. Manner of eath 28b. Time of 28d. Describe how injury occurred Date of Injury 28c. Injury at Work? After t (Month, Day Year, Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide determined certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

6+1

State Registrar

And De Les n 31. Date filed (Month, Day, Year) Decern

29b. Signature and title of certifier

JUN 2 2 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins 32. Registrar's Signature

medical Doctor

Hospital 400 North Wolfe Street

29c. License number

29d. Date signed (Month, Day, Year)

Baltimore raylow

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ) cm 200 Irma S. Geyer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore-Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 □ X 220-18-4330 Director 17, 1926 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director Maryland Baltimore Dunda1k 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 1952 Wareham Road United States items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes ZXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 0 1 ☐ Yes 2 ☑ No Specify: þ permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exagonee. 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Data Entry--Social Security U. S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gideon N. Sauter Edna Schroeder 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret L. Corner (Daughter) 1952 Wareham Road Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State Donation 5 Other (Specify) Lorraine Pk. Cemetery 6/25/2007 Woodlawn, Maryland 21. Signal of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Avenue Dundalk, Marylan Inc. 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical a consequence of) Examiner Sementially list conditions, if Any, learning to immediate gause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 2 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only orth Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manufer of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: 1 Natural Accident (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed death. after death. filled in by the within 24 hours a

To the Funeral I

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion death. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD f person who completed cause of death (Item 23a) (Type, Print 30 Registrar's Syriature 30. Name and address Whokn

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

6 ☐ Could not be

determined

3 ☐ Suicide

29a. Certifier

4 Homicide

31. Date filed (Month, Day, Year)

JUN 22

2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State

Registrar

MARCARIAN 07-04616		
UNK UNK	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene	. 1
	1- For State Registrar Certificate of Death Reg. No.	. l
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year June 17, 2007  3. Time of Death Month Day June 17, 2007	
	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death	
	University Hospital  5. Social Security Number  6. Sex  7. Age (In vrs. last birthday)  If Under 1 Year   If Under 24Hrs.   8. Date of Birth (MM/DD/YYYY)   9. Birthplace (State or	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Proreign Country) Months Days Hours Min.	,
	Usual Residence of Decedent	1-100
low any	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lim	
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at once. Be Completed by Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
h the M 3a or 2 ootified	2865 W. GANGA AUG 21215 USA	
or items 23 must be no	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.	
her de	3 Widowed 4 Divorced If Yes 2 No 1 Yes 2 No specify: Specify: Specify:	
hours Fxami	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	
5-0036 ed within 72 hour lygiene. other than "matt the Medical Exal	WK grade LABOIEN Temp Agency	
21215-0036 ulid be filed within 72 hours al Mental Hygiene. marked other than "natural event, the Medical Examin	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)  EGINAL EVETTE FRIMES	
Z = 2 = 3   0	LEGINAL   FUEDETICK   EUSTIC   CRIMES     19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
AD 2 sho	EUETTE WEBB MOTHER 3214 RAMOND AUG BOLFINAR Med 2121.  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery) Date , 20c. Location - City or Town, State	3
Ore, Ngs I and of Health	1 Burial 2 Cremation 3 Removal from State crematory or other place)	,
Baltimore, permit. Pages I a Department of He Important: If ite injury or other to	4 Donation 5 Other Specify: King Henwral Ind 3/07 Wood Chushy 121. Signature of Funeral Service Licensee 22. Name and Address of Facility	De.
Ba Pern Inip	Delay Forming 5240 pers terstown ld Boltmore All 210	2/)
Physician // /Medical	23 . Lart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line.  Approximate International Control of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allure. List only one cause on each line.	
Examiner	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	- 22
_	Sequentially list conditions, b. lif any, leading to immediate Due to (or as a consequence of):	
iit Xamine	cause. Enter Underlying Cause	
11/ 8 2 11	events resulting in death) Last Due to (or as a consequence of):  d.	
be execute ician and irial - tran	UNPENDED AMENDED	
that the death certificate be executed by the attending physician and detached for use as the burnal - transby Physician/Medical Is	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Year	
DX 60 ath cert attending or use a sicia	past 12 months?  4 Pregnant at time of death 5 Other (Specify)	1
D. Bo trithe de by the ached f	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?	
tal Records, P.O. B. cian: The law requires that the de certificate has been signed by the ector, page 2 should be detached I Be Completed by Phy	1 Yes 2 ✔ No 3 Probably 4 Unknow	'n
ords w requ as been s should	24a. Was an 24b. Were autopsy findings availa autopsy prior to completion of cause of autopsy prior to completion of autopsy prior to completio	
Records, F The law requires froate has been sig	performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No	
Division of Vital Records, tat or Attending Physician: The law requirers after death al Director: After this certificate has been si led in by the funeral director, page 2 should bertification: To Be Completed	25. Was case referred to medical examiner?  1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence 6 Other:	
Of Ving Phy ing Phy After th Tuneral (Tuneral on T To	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	
Sion Attendi death ector: by the f	2 Accident Investigation Jun 17, 2007 0147 hrs	NiA.
Division o prital or Attending ours after death teral Director: After filled in by the fume Certification:	3 Suicide 6 Could not be determined (Specify) Multi-Family Apt. 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural Route Number, Cor Town, State) 2613 Fairview Avenue Apt.D, Baltimore, Md.	ity
o life ou	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
To the Hos within 24 h To the Fun completely Medical (	and manner stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	
	O.C.M.E. June 17, 2007	
h	30. Name and address of person who completed cause of death (Item 23a)	
	Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  31. Date filed (Month, Day, Year) 32/Registrar's Signature	
State Registrar	The state of the s	

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Monthune Days, 2007 11:50A M Eugene F. Gottemoller 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Saint Joseph Medical Center Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days X□ M 2□ F 278-12-5208 85 Feb. 12 1922 Ohio Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State 1 ☐ Yes 2 ☐ No MDBaltimore Timonium 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 14. Race - American Indian, Black, White, etc. 21093 210 Belmont Forest Ct. #208 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 X No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Service Engineer Packaging 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Goettemoeller Catherine Hemmelgarn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 210 Belmont Forest Ct. #208, Norma J. Gottemoller/wife Timonium, MD 21093 Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory 4 Donation 5 Other (Specify) 6/19/07 Catonsville, MD 21. Sunth of Fune al Service Locuston 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 Bryan W. Clary Approximate Interval Between Onset and Death that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so on each line. 23a. Part1. Enter the disease, or complic shock, or eart failure. List only one Immediate Couse (conal disease or condition resulting in death) PNEUMONIA Due to (or as a consequence of): URINARY TRACT INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): RENAL FAILURE Due to (or as a consequence of) IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2▼ No 24a. Was an autopsy 2 **2** No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation

attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, sate has been signed by the a page 2 should be detached it s after deau. rai Director: Aftr

within 24 hours a To the Funeral C

**Physician** 

/Medical

**Examiner** 

Director

by Funeral

Completed

Be

Examiner

Physician/Medical

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Completed

Medical Certification: To Be

**Funeral** 

Director

Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician** /Medical

Examiner

Baltimore, Maryland 21215-0036

2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

D41410

200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARYLAND 21204 OSLER DRIVE TOWSON, JOGINDER P. 7601 MEHTA

31. Date filed (Month, Day, Year) Registrar

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Day Year Month Gelzhiser 20,2007 JUNE 4b. City, Town, or Location of Death 4c. County of Death AGNES HOSPITAL BAUTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Hours | Min. | Jun 24, 19 7. Age (In yrs. last birthday) 1 □ M 2 F Months 1940 66 10c. City, Town or Location 10b. County

202 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 21:24 8 Katherine Louella /Medical 4a. Facility Name (If not institution, give street and number) Examiner SAINT Birthplace (State or Foreign
Country) Social Security Number **Funeral** Pennsylvania 193-30-7231 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo MD Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21228 12 Turk Garth permit. Pages 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene.} Important: if item 27 is marked other than "natural", or items 23s amy Injury or other traumatic event, the Medical Examiner must once. Funeral 12, Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Long Term Healthcare 12 Nursing Home Administrator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helen Catherine Winter Leroy Howard Gelzhiser 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Turk Garth Catonsville, MD 21228 Howard Gelzhiser/brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 06/22/07 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service License Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPTIC SHOCK SECONDARY **Physician** TO NEUTROPENIC HOURS resulting in death) /Medical Due to (or as a consequence of): FEVER Examiner UNICHOW NON SMALL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy 2 No 1 TYes 1☐ Yes 2 NO Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient မ 2 ER/Outpatient 3 DOA Director: After this in by the funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 5 Pending investigation 1 M Natural 1 ∏Yes 2 ∏No death. 2 ☐ Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I l 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) Jasmin alittamirani, MD IUNE; 20, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Igsmin alittamiani, mo, 900 catan Arenve, Bellimore mo, 21229.

Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

31. Date filed (Month, Day, Year)

**ORIGINAL** 

			1- State Amend item 25	tate of Maryland per ME,G868,	d / Depa <b>06/25</b> /	rtment of H	ealth and N Death		iene	7	20220	
ı	Physici: /Medic		1. Decedent's Name (First, Middle, Last)		H	amiltor	7	2. Date of Dear Month May	Day	Yeer 207	3. Time of Death 8:03 PM	
	Examin		4a. Facility Name (If not institution, give stre Johns Hopkins F			4b. City, Town, or Balti			4c. County of Death NA			
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. It	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) -1990	9. Birthp Coun	lace (State or Foreign try)  Md.	
	death with the Maryland ms 23a or 28a-f show mat be notified at	Director	Usual Residence of Decedent   10a. State	10c. City	, Town or Loc Ba ]	ation timore				1	0d. Inside City Limits  1 Y Yes 2 □ No	
	th with th 23a or 21		10e. Street and Number 967 Sandlewood F	≀d.		10f. Zip Code 212	221	1	0g. Citizen of W USA	hat Coun	itry?	
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0-0171	within 72 ho ene. than "natur re Medical	Completed			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student					siness/Inc	dustry	
ana z	ild be filed within lental Hygiene. Ked other than itc event, the M	Be	8th grade  17. Father's Name (First, Middle, Last)  Anthony	Hamil			18. Mother's Nam	e (First, Middle, I	NA Maiden Sumame McCre	•	Υ	
Mary	d 2 shouth and N 7 is mar traumal	2	19a. Informant's Name/Relationship (Type, Tonya Hamilton	Print) Mother	19b. Mailing 967	Address (Street a	nd Number or Rur	a/ Route Number	City or Town, S imore,	itate, Zip Md	<sup>Code)</sup> 21221	
more,	Pages 1 and Healt of Healt of Healt of Healt of Healt out: If Item 2 iry or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	metery, crem	ition (Name of atory or other place	9)	Date 5-07	20c. Location - 0 Randa	-	wn, State town, Md.	
Dall	permit. Page Department of Important: If any njury or		21. Signature of Funeral Service Licensee	o ane		Name and Addres		March F Ave., B	.H. Ea altimo	st re,	Md.21202	
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O. Box o	death certific e ettending p	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	If yes, outcome of pregnar 1∐Live birth 2 ∏Fetal 4∏Pregnant at time of de 9∭Unknown	death 3 □I	Ectopic pregnancy Other (specify)			23d. Date Mon		ry Day Year	
cords, r	The law requires thet the stee has been signed by the page 2 should be detached.		Part II. Other significant conditions contrib hypoTnyrol als M		lting in the un	derlying cause give	n in Part I.	23e. Did tob			e cause of death?	
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VII	siclen: s certific lirector,	Be	25. Was case referred to medical examiner?  1 ★ Yes 2 ★ No Hosp	pital: 1 ✓ Inpatient 2 □ 8	ER/Outpatient	3ELDOA Othe	26. Place of Deat	h <i>Check only on</i>	-	. (0		
	To the Hospitel or Attending Physicien: The law within 24 bours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	ation: To			28b. Time of Injury	28c. Injury Work		28d. Describe ho			0	
	tel or Atte s after des el Directo ed in by th	Certification:	3 Suicide 6 Could not be determined	8e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (St. City or Town	reet and Numbe i, State)	r or Rura	l Route Number,	
	Mospil 24 hour Funer letely fill	edicai	29a. Certifier 1 Certifying Physici. (Check only one) 2 Medical Examiner:	on: To the best of my know On the basis of examinati and manner stated.	vledge, death on and/or inve	occurred at the timestigation, in my op	e, date and place, inion, death occur	and due to the cared at the time, da	ause(s) and man ate and place, a	ner as st nd due to	ated. the cause(s)	
	within To th comp	Me	29b. Signature and title of certifier	DO M	D	29c. License Res -			9d. Date signed			
	9		30. Name and address of person who comp	leted cause of death (Item	4 .			Baltim	ore M	D	21287	
	Sta Registr	-	31. Date filed (Month, Day, Year) JUN 2 1 2007	32. Registrar's Signat			/	<u> </u>				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:10 AM 2 2001 HUGHES RITA MARIE /Medical 4a. Facility Name (If not institution, give street and number, County of Death 4b. City. Town, or Location of Death Examiner Kn かけも Baltimore-Washington Medical Center 8. Date of Birth (Month Day, You April 29 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6 Sex 7. Age (In vrs. last birthday **Funeral** New York Days Hours Min 1 □ M 2 M F 096-16-8497 85 Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a. State 10b County 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notified at Pasadena 1 ☐ Yes 2 X No Anne Arundel Maryland Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? U.S.A. 21122 1422 Pond Ridge Drive permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must bonee. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify. δ 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk Tool Manufacturer 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Flanigan Downs David ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1422 Pond Ridge Drive, Pasadena, Maryland 21122 Thomas M. Hughes (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 3 ☐Removal from State 1 Burial 2 ☐ Cremation St. James Cemetery 06-23-07 Waverly, New York 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility 21. Signature of Funeral Service Licensee McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 Kun 23a. 5ar 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one abuse on each line. remediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a or sequence of) **Examiner** Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed Age Age Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4□Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 🗌 Yes 2 🗌 No 3 Probably 4 □Unknown Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 No 1∐ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 25 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dipatient 2 ER/Outpatient 3∏ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1-Matural 5 Pending investigation 1 Tes 2 Accident hours after death uneral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. 29b. Signature and title of certifier mb

12

State Registrar 30. Name and address of person who completed cause of death (Item 23a)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MARIAR S

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month Heisler **Physician** Katherine, June 1539 00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner of Maryland Medical Center Baltimore nla University 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 √F July 20, 1959 Maryland Director 212-80-3291 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show important: if Item 27 is marked other than "hatural", or items 23a or 28a-f show inportant: if Item 27 is marked other than any injury or other traumatic event; the Medical Examiner must be notified at any once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐Yes 2 No Middle River Directo Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral United States
14. Race - American Indian 21220 12 Tomahawk Terrace 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: ģ 3 ☐ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) +2 Registered Nurse Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert J. Heisler Agnes M. Kelly 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12 Tomahawk Terrace Baltimore, Maryland 21220 Patricia E. Franey (Partner) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【▼ Cremation 3 ☐ Removal from State Hilltop Service Corp. 6/21/2007 Towson, Maryland UDonation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediate Cause (Final disease or condition resulting in death) 6 month **Physician** Non-small /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician; The law requires that the death certificate be executed as the burial-transi and Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☑ No Day detached for 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 MInpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 ☑ Natural After (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

The Funeral Director: A pletely filled in by the filled in by the filled in 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Mcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier June 19 2007 17471 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 Baltimore MD 21230; Dr. Ashlev South Greene Street, 31. Date filed (Month, Day, Year) JUN 2 2 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

# 07-04404

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	Re	egistrar Decedent's Name	First Midd	le Last)		Cer	lincale	OI Deal				Date of Death		V	3. Tim	e of Death
Physician/  N I Examiner		Craig			ntwon		Hun	ter			J	Month June 8, 200		Year		08 hrs
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Baltimore, MD 21215-0036  permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiera has a financiant. If items 13a or 28a-f sho important: If item 7 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once I Dea Completed by Funeral Director	2	19a. Informant's N	ame/Relation זאז : 1 1 זי	nship (Tyr i ams	oe, Print )		2	233 E.	Nor	th Av	e., E	Baltimo	re,	Md. 2	2121	3
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687 ertific ding p	sician/M	23b. Was deceder past 12 monti	nt pregnant ir hs?	n the	1 Live birth  Pregnant a	at time of	death 5	Fetal dea		3Ectopi	ic pregnan	icy	\ \ \ \ \ \	<b>M</b> onth	Day	Todi
Box 6876( e death certificate the attending phy ed for use as the b	Sic	1 Yes 2	No 9 🔲 l	Unknown	g Unknown		5	Other (S	specify)		Familia					
	Phy	Part II. Other sig	nificant con	ditions	contributing to dea	th but no	t resulting i	n the underly	ying caus	e given in P	Part I.					eause of death?
P.(	٩															y findings availabl
rds requi	턀											24a. Was		prior deat	to comp	letion of cause of
eco he law ite has	Completed											1 Yes			Yes	2 No
Division of Vital Records, P.O. Box 6876 rate or Attending Physician: The law requires that the death certificate is after death.  In Director: After this certificate has been signed by the attending physical in the funeral director, page 2 should be detached for use as the	e l	25. Was case ref	erred to med		7				26.PI	Other		7.5			A the second	
Vita hysich this of	ල ල	examiner?	2 No_		lospital: 1 Inpat	-	✓ ER/Out		DOA	njury at Wor		Home 5 28d. Describe	Resider		other:	
ing Pl After Funera	n: T	27. Manner of De			28a. Date of Ir (Month, Day Jun 8, 2007	njury ,Year)	1947	me of Injury hrs	1	Yes 2	15	Subject sh		,		
Sion ttend death ctor:	atic	2 Accident		Pending nvestigati			thome far	m street fac	tory offic			28f, Location	(Street ar	nd Number o	r Rural F	Route Number, Cit
Jivis Il or A	Certification:	3 Suicide	- d	Could not letermine	be			iii, 50 550, 140	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			or Town, 1900 blk N.	Ctata)			
spi net / fil		4 Homicide	7	a Physici	To the boot of	mu ka oud	ledge deat	h occurred a	it the time	e, date and p	olace, and	due to the ca	use(s) and	manner as	stated.	
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Medical	(Check only one) 2	✓ Medical I	Examine	en: To the best of example:  on the basis of example:  and manner state	kaminatio	n and/or in	vestigation, i	n my opir	nion, death o	occurred a	t the time, dat	e and pla	ce, and due	to the ca	
To To con	Me	29b. Signature a	nd title of cer	rtifier	and manifer state					ense numbe	er			Date signed	,	Day, Year)
		J	osh	Me	01 W	0			0.	C.M.E.			June	e 9, 2007		
$\Omega_{c}$				rson who	completed cause o	f death (f	tem 23a)	444-		D-00	050 NAT	24204				
7		Tasha Gr	eenberg N	MD.	Assistant Med			111 Per	nn Stre	et, Baltim	iore, ML	J Z  ZU				
Sta	ate	31. Date filed (M	lonth, Day, Ye	ear)	32. Regis	ırar's Sigr	nature	A								
Regist			JUN 2	2 200	7 1000		100 - B	recht p	7							

07-04609 Melvin Hill Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

eivin Hill		For State	of Maryland / D		ificate of		ila Merite		eg. No.	200	1 2022	
Physician		e <b>gistrar</b> . Decedent's Name (First, Middle,Las	t)	560				Date of Dea     Month	ith Day	Year	3. Time of Death 1742 hrs	
edical Examine		Melvin  a. Facility Name (if not institution, given	Hi.		T 4	h City Town	or Location of I	June 16,	2007	County of Death	17421115	
	4	829 W. Cross Street	e street and number)		7	Baltimore	or zoodion or			NÁ		
Funeral	5	5. Social Security Number 6. S	ex 7. Age (Ir	yrs. las	t birthday)	If Under 1 Y		24Hrs. 8. Date of B	rth(MM/DI	D/YYYY) 9. Birtl Foreigi	nplace (State or	
Director		242-60-7743	M 2 F	7	71 Yrs.	Months D	ays Hours	12-1	4-193		untry) N.C.	
any	-	Usual Residence of Decedent  10a, State  10b, County	100	c. City, T	own or Location	on				10d. Inside City Limits		
<b>*</b> .		Md. NA		E	Baltimo	re		100			1 X Yes 2 No	
Maryland 28a-f show d at once.	Director	0e. Street and Number				10f. Zip Code			10g. Citize	en of What Coun	itry?	
ith the Mary 23a or 28a notified at		829 W. Cross St			140 141-		230	2 / Specify Voc. or N	0 11	USA	can Indian, Black,	
ath wil	ᇒᅵ	<ul><li>11. Marital Status</li><li>1 Never Married 2 Married</li></ul>	12. Was Decedent Eve Armed Forces?					n? (Specify Yes or No Puerto Rican, etc.)	,	White, etc.		
frer de	وا آ	3 Widowed 4 X Divorce	1 X Yes 2 If Yes, Give Year or Dates:			Yes 2X					lack	
natura Exami	g	15. Decedent's Education (Specify of	only highest grade comple	ted)			pation (Give ki ife, DO <b>N</b> OT u	nd of work done se retired)	16b. Ki	nd of Business/I	ndustry	
Imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.  ant: If iten 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	ompleted	Elementary/Secondary (0-12)  12th grade	College (1-4 or 5+)		Sup	ervisor				Diploma	nt Tire Co.	
5-0036 iled within 7. Hygiene. d other than , the Medica	히	17. Father's Name (First, Middle, Las			Dup	<u> </u>	18.Mother's	Name (First, Middle		Surname)		
21215-( uld be filed a Mental Hygis marked oth	8	RAY 19a. Informant's Name/Relationship (	HIL.	L	19h Mailing	Address (St	KAT	er or Rural Route N	ımber. Cit	FREEMAN v or Town, State	- 7.5-1	
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and N Important: If riem 27 is m injury or other traumatic.	- 1	Tyrone Rogers	Stepson					eet, Balt			21230	
e, N I and Health Fitem		20a. Method of Disposition	Removed from State		lace of Dispos	ition (Name of her place)	cemetery,	Date	20c. L	ocation - City or	Town, State	
Pages		4 Donation 5 Other Specifi	y:	Gr	eenmou	nt Cem		6-23-07		Baltimor	e, Md.	
Baltimore, permit. Pages 1 ar Department of Hes Important: If ite Imjury or other in		21. Signature of Funeral Service Lice		\	22. N	Name and Add		March Balt	H.	East e, Md.	21202	
Physician	+	23a. Part I. Enter the disease, or con	plications that caused the	e death.							Approximate Interval Between Onset and	
Medical		failure. List only one cause on a Immediate Cause (Final disease	each line. a. Atherosclerotic Ca	ardiova	ascular Dis	ease					Death	
Examiner	-	or condition resulting in death)	Due to (or as a consequ	ence of	):							
	اچ	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	ence of	):							
		Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of	):						<del> </del>	
cuted	<u>~</u>		d								<del> </del>	
60, ate be executed hysician and te burial - transit	gici	UNPENDED	AMENDED	_					224	. Date of deliver	1	
8760, tificate bing physicas as the bun	Ž	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome  1 Live birth	of pregr		etal death	3 Ectopic	pregnancy			Day Year	
Box 6876( death certificate he attending physicate d for use as the b	Physician/	1 Yes 2 No 9 Unknow	4 Pregnant at tin	ne of dea	ath 5 O	ther (Specify)			1			
that the dened by the detached f	튑	Part II. Other significant condition		ut not re	esulting in the	underlying cau	se given in Par				the cause of death?	
P.O.	à p	Chronic Alcoholism									bably 4 V Unknown	
ords, w requir	etel								as an topsy rformed?		utopsy findings available completion of cause of	
Reco	Completed							1 ✓ Ye	s 2 N		es 2 No	
ital Recitan: The scertificate rector, page	åi	25. Was case referred to medical examiner?	Hospital: 1 Inpatient	2	ER/Outpatien		Other	Check only one)  Nursing Home 5	Reside	ence 6 V Othe	er: Scene	
n of Vi ling Physu After this funeral dir	<u>د</u>	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day,Yea		28b. Time of		Injury at Work		e how inju	ury occurred		
ion (tendin eath.	atio	1 Natural 5 Pending 2 Accident Investig	ation				Yes 2					
Division of Vital Records, tal or Attending Physician: The law requirers after death.  "I Director: After this certificate has been sited in by the funeral director; page 2 should be	Certification:	3 Suicide 6 Could n	ot be 28e. Place of Injur	ry - At ho	ome, farm, stre	eet, factory, off	ice building, et	c. 28f. Location or Town	n (Street a ı, State)	and Number or R	tural Route Number, City	
Ospita lospita l hours	<u>8</u>	29a. Certifier	ician: To the best of my	cnowled	ge, death occu	urred at the tim	e, date and pla	ice, and due to the c	ause(s) an	nd manner as sta	ated.	
Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physocompletely filled in by the funeral director, page 2 should be detached for use as the b	Medical	(Check only one) Medical Examin	ner:On the basis of exami and manner stated.	nation a	nd/or investiga	ation, in my op	nion, death oc	curred at the time, da	ite and pla	ace, and due to t	the cause(s)	
F. 2 5 8	Me	29b. Signature and title of certifier					cense number			Date signed (M	onth, Day, Year)	
		1 Leter	ewy)				.C.M.E.		Jun	e 17, 2007		
10		30. Name and address of person what Laron Locke MD. Ass	no completed cause of de istant Medical Exar			n Street, B	altimore, M	D 21201				
St	ate	31. Date filed (Month: Day, Year)	32. Registrar's	Signati	ure	****						
Regist		JUR 2 %	2007   Lilanes	and and	J. 100	84823						

			1 - For State Registrer	State o	f Maryland	-		nt of Health an te of Death	id Mental	Hygien Reg. N	200	7	20225		
	Di		1. Decedent's Name (First, Middle	, Last)					2. Date	of Death th Da	ay Yes	ar	3. Time of Death		
	Physici /Medio		John Edward He	aly					Jun			7	8:30 A.M.		
	Examir		4a. Facility Name (If not institution	, give street and nur	mber)		4b. Cit	y, Town, or Location of D	Death	4	c. County of D	eath			
			Baltimore Wash	ington Me	dical Ce	enter	G	len Burnie			Anne A	run	del		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I		If Und Month	er 1 Year If Under 24 S Days Hours I	Hrs. 8. Date Min. (Mon	of Birth th, Day, Year	9.	Birthpla	ce (State or Foreign		
	Director		218-18-0346	1(XM 2□ F	82	Yrs.	WORLD	Says Hours	01/	01/18/1925 Maryland					
	p ,		Usual Residence of Decedent  10a. State 10b. County		10a Cib	, Town or Lo						10	d. Inside City Limits		
	aryla ehov	_										10	1 ☐ Yes 2X No		
	8 - f	ctc		Arundel	Pas	sadena						170			
	ith t	ä	10e. Street and Number					ip Code			Countr	y?			
	72 hours after death with the Maryland naturel', or items 23a or 28e-f ehow disal Examinar must be notilled at	Funeral Director	1918 Cedar Ro					21122-3803			J.S.A.				
	er de	n n	11. Marital Status	Armed Fo		S. 13.	Was Dec If Yes, sp	edent of Hispanic Origin ecify Cuban, Mexican, P	? (Specify Yes Puerto Rican, et	or No-	14. Race - A Black, W				
36	s aft	by F	1 ☐ Never Married 2 ☐ Marri 3X Widowed 4 ☐ Divorced	If Yes, Giv	2∐No ve		1 🗌 Yes	2 No Specify:			Specify:	Whi1			
21215-003	hour furei	효	15. Decedent		ates: WW II		dont's He	ual Occupation		165	Kind of Busine				
5	C 2	Completed	(Specify only highes	t grade completed)		(Give	kind of v	vork done during most of use retired)	f working	100.	Cind of busine	355/1100	istry		
12	within ene. then "	Ĕ	Elementary/Secondary (0-12) 1 2	College (1	1-4or 5+)		gine			Fnc	ripori	na	Industry		
0	be filed within 72 hours after death with the Marylan stall Hygiene.  Indicate than "naturel", or items 23s or 28e-1 show other than "naturel", or items 23s or 28e-1 show event, the Madical Examiner must be notified at		17. Father's Name (First, Middle, I			1111	griie		Name (First, A			.rrg	Industry		
a	Elementary/Secondary (0-12)  College (1-4or 5+)  12  4  Engineer  18. Mother's Name  Julius Healy  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural)								ian Lor						
Maryland	2 shoul and Mais is mari	ဥ	Julius Healy  19a. Informant's Name/Relationsl	nip (Type, Print)		19b. Mailir	ng Addre	ss (Street and Number of			or Town, Stat	e, Zip (	Code)		
S	s 1 and 2 should f Health and Mer item 27 is marke other treumatic		Jeffrey Healy	(son)		1	•	ar Road -		1.00	aryland		1122–3803		
5	s 1 and 3 If Health item 27 other tr		20a. Method of Disposition	(SOII)	20b. PI	ace of Dispo	sition (N	ame of	Date		ocation - City				
2	nit. Page artment o ortent: If injury or injury or		1 Burial 2 Cremation		State	emetery, cier Prose V	-		6/23/20	)07 Tin	miim	Ma	ryland		
Baltimore,			4 Donation 5 Other (Specify)  Dulaney Valley Mem.Gdn.06/23/2007 Timonium, Maryland  21. Signature of Funeral Sarvice Licensee  22. Name and Address of Facility E. F. Lassahn Funeral Home, F												
Ba	Depariment of the permit of th		6	2	,			Belair Roa					•		
			23a. Part1. Enter the disease, or	complications that of	caused the death			<del></del>			le, riai	_	Approximate		
			shock, or heart failure. List only one cause on each line.  Interval Between Onset and Death  Onset and Death												
	Physician /Medical		disease or condition resulting in death)	- a HINA	ro suero	TIC	CON	anovas man	$\sqrt{q_1}$	5.2942		<u> </u>			
	Examiner			Due to (or as a consequence of):											
		e	Sequentially list conditions, if any leading to immediate	b. Due to	(or all a consequ	ience of):	M	1 to Lotte	2						
1	red	든	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Elhom		Can	Lamente	the said						
Th.	be executed sicien and burial-transit	Examln	that initiated events resulting in death) Last	c. Due to	(or as a consequ	ence of):	C		7						
8760次	cate be executed physicien and the burial-transit	dical							,						
89	ficate physics the	ğ		0.											
Вох	The law requires that the death certific Ite has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregnar						23d. Date of	deliven	,		
ă	death a atte	cla	in the past 12 months? 1 ☐ Yes 2 ☐ No		ointh 2 ☐ Fetal nant at time of de		∃Ectopic ∃ Other (	pregnancy specify)			Month		lay Year		
P.O.	thet the de ted by the a detached	nys	9 Unknown	9□ Unkn	own										
σ.	s thet	by PI	Part II. Other significant condition	ns contributing to d	eath but not resu	ulting in the u	nderlying	cause given in Part I.	23e	. Did tobacco	use contribut	e to the	cause of death?		
rds	quires n sign	D D								1 ☐ Yes	2 □ No 3	Proba	bly 4 ∐Unknown		
Records,	w requ	Completed							24a	. Was an	24b. Were	autop	sy findings available		
Re	The law ate has page 2 t	Ĕ							_	autopsy performed?	prior	to com	pletion of cause of		
										Yes 2	! □ No				
Vital		O B	examiner?	Hospital:	Inpatient 2 🗆 I	FD/O: 44i		Other	Death (Check						
ŏ		-	27. Manner of Death	28a. Dite	of Injury	ER/Outpatier 28b. Time o		28c. Injury at Work?	ng Home 5 28d. Des	cribe how inj		эр <i>өс</i> ігу)			
6 # 6 4 2   # 1 TVo 2 TNo															
/isi	Attendii r death. sctor: A sy the fu	flea	3 ☐ Suicide 6 ☐ Could r	ined 289. Place	of Injury - At ho	me, farm, str	reet, facto	ory, office				r Rural	Route Number,		
á	after Dire	ert	4 ☐ Homicide	buildi	ing, etc." (Specify	')			City	or Town, Sta	le)				
	spits nours nersi		29a. Certifier 1 Certifyin	g Physician: To the	best of my know	wledge deet	h Securis	d at the time date and ;	lane, and the	to the dausel	s) and marrier	r as sta	tad		
	Ho 124 P Fu Fu letely	Medical	(Check only 2 Medical one)	Examiner: On the b	asis of examinat ner stated.	ion and/or in	vestigatio	on, in my opinion, death	occurred at the	time, date ai	nd place, and	due to 1	he cause(s)		
	To the Hospital or Attencythin 24 hours after death To the Funeral Director: completely filled in by the	×	29b. Signature and title of certifier				2	9c. License number		29d. D	ate signed (M	lonth, D	ay, Year)		
			AZ CA	m	M			D 43977	1	II.	1. 7	o	4007		
			30 Name and address of person	who completed caus	se of Neath (Item	23a) (Type,	Print)	- 111		Jun	~ 0	-	/		
	15+1		Moke money	30/01/	of Index	we al	lan 1	mi- m	21061						
	Sta	ite	31. Date filed (Month, Day, Yeal)		Registrar's Signat	ture		11:12	-17 01						
	Registi		JUN Z Z Z	JUI SEEM	and the	AST NO.									

DHMH 17 Hev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 1735 M HENDERSON 2007 06 JERONICA L /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MEDICALCENTRE JOHNS HUPKINS BAYVIEW BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Month, Day 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9 Birthplace (State or Foreign **Funeral** 1 □ M 2 🔯 F Director laryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Director more 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) (Huss 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) bara t Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐Removal from State Park 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 23a. Part | Enter the clease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediale Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of): **Physician** /Medical Due to (or as a consequence of) **Examiner** middle cerebral antity stoke Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the burial-tran Due to (or as a consequence of) attending physician for use as the hirrial Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Nonknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s has autopsy certificate 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records, P.O. Box 68760,

Maryland 21215-0036

Baltimore,

The law requires that the death certificate be executed the Hospital or Attending Physician; after death.

Director: After this certific To the Hospital o within 24 hours aft To the Funeral Di completely filled in

H	
Sta	
Registr	ar

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

RESODO

BALTIMORE

2007

21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deizswalom

4940 EASTERN AVENUE D MUTHUCOVINDAN

31. Date filed (Month, Day, Year) JUN 22

2007



			State of N State of N State of N State of N Registrar	laryland erffl, 686	/ Depa 8, 6/2 Cer	artment of H fificate of L	ealth and N Death	lental Hyg	giene 2 (	007	20227			
	Physici	an	1. Decedent's Name (First, Middle, Last)	14.6	T			2. Date of Dea		Year	3. Time of Death			
1	/Medic Examin	al	4a. Facility Name (If not institution, give street and number	,, ,,	/	4b. City, Town, or	Location of Death	0 Zu	4c. Cour	200 /	7-50 A M			
			5. Social Security Number 6. Sex 7.	ge (In yrs. last	hirthdoul	Baltin If Under 1 Year	10 °C If Under 24 Hrs.	8. Date of Birt	NA	O Rieba	lace /State or Femine			
	Funeral Director		215-28- <del>6927</del> 6976 6.5ex 1□ M 2☒F	Yrs. Months Days Hours Min. Month, Apr 25			Apr 25,	1933	Mary					
	/land		Usual Residence of Decedent  10a. State 10b. County	10c. City, T	own or Lo	cation				10	0d. Inside City Limits			
	Se-feh	octor	MD	]	Balti						1x Yes 2 □ No			
	death with the Maryland ms 23a or 28e-f ehow rmust be rediffed at	Funeral Director	10e. Street and Number 115 E. Melrose Avenue			10f. Zip Code	1212		10g. Citizen o	of What Coun USA	try?			
	er deat	uner	11. Marital Status 12. Was Deceder Amed Forces	t Ever in U.SH	ńk 13. V	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		lace - Americ lack, White,				
036	be filed within 72 hours after death with the Marylan ital Hygiene. Id other then "naturel", or Items 23a or 28e-f ehow event, it a Medical Exacting must be tradified at		1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates		1	1 ☐ Yes 2ሺ No	Specify:		Spec	cify: bla	ck			
21215-0036	in 72 ho "natur	Completed by	15. Decedent's Education (Specify only highest grade completed)		6a. Deced (Give life, L	dent's Usual Occupa kind of work done of DO NOT use retired	ation furing most of work	unk	16b. Kind of	Business/Inc	lustry <del>unk</del>			
	e filed within at Hygiene. other then "	Сош	Elementary/Secondary (0-12)  unk  College (1-40  unk	(5+)	aregiv	ver				Care Fa				
and	id be fill enta! H ked oth ic even	To Be	17. Father's Name (First, Middle, Last) William Huff			unk	18. Mother's Nam <b>Alberta Bu</b>		Maiden Sum	ame)	<del>-unk</del>			
Maryland	s 1 and 2 should by f Health and Menta Item 27 is marked other traumatic ev	۲	19a Informant's Name/Relationship (Type, Print) Glenna L. Levis	1	19b Mailin	ng Address (Street a W. Baltimon Loch Rav			3 City or Tow	vn, State, Zip	Code)			
	s 1 and of Health Item 27 other tr		20a. Method of Disposition	20b. Place	e of Dispo	sition (Name of natory or other place	1	Date		n - City or To				
Baltimore			1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in 3 tate		Belts									
Ba	permit. Page Depertment of Important: If eny injury or once.		21. Signature of Euro ral Service Licensee Rade, Wade, Wade,	ector	- 3	Name and Address	comy Dogr	A CCO D	DULE.	Pasture	bereer			
			shook, or heart failure. List only one cause on ach	ed the death. I							Approximate Interval Between			
I	Physician /Medical													
ł	Examiner		Sequentially list conditions, b. Non	Male	NA	ule	215 07	698	3		tweeks			
V	uted d ansit	Examiner	Tany leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	0 P (0	na offi	Sheial	1/10800	dolo	lisea	30				
60,	icate be executed physicien and the burial-transit			is a consequen	ce of):									
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Вох	death certific e attending p od for use as t	Physician/M		2 Fetal de	ath 3	Ectopic pregnancy				Date of delive Month	ry Day Year			
P.O.	0 0 0	hysic	1 Yes 2 No 9 Unknown 9 Unknown	at time of death	1 5	Other (specify)				<u> </u>				
	es De d	Ď	Part II. Other significant conditions contributing to death	but not resultin	ng in the ur	nderlying cause give	en in Part I.		obacco use co ⁄es 2 □ No		e cause of death? ably 4 Donknown			
Records,	e law requii has been s je 2 should	Completed						24a. Was	an 24t	b. Were autop	osy findings available inpletion of cause of			
al B	age Th	e Con	25. Was case referred to medical					perfo 1 ☐ Yes	20 No	death?	2000			
ž Vij	iding Physicien: th. : After this certifica i funeral director, p	To B	examiner? 1 Tyes 2 No Hospital: 1 Inpa		/Outpatien	t 3 DOA Othe	26. Place of Deat er: 4 ☐ Nursing Ho	ome 5 Resid		Other (Specify	1)			
ouo	nding P th. : After t s funera	tion:	27. Mann of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of In  (Month, E	jury Jay Year) 28	b. Time of Injury	Work	yat ⟨? Yes 2 □No	28d. Describe h	now injury occ	curred				
Division of Vital	To the Hospital or Attending within 24 hours effer death.  To the Funeral Director: Affer completely filled in by the fune	Certification;	3 Suicide 6 Could not be 28e. Place of I	niury - At home etc. (Specify)	, farm, str	eet, lactory, office		28f. Location (S City or Tov		mber or Rura	l Route Number,			
	ospital hours e uneral I iy filled		29a. Certifier (Check only)  29 Medical Examiner: On the basis	st of my knowle	dge, death	occurred at the tim	ne, date and place,	and due to the	cause(s) and	manner as st	ated.			
	o the H ithin 24 o the F omplete	Medical	one) and manner	stated.	andorm	29c. License			29d. Date sign	ned /Month	Day Year)			
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_	ン		30. Name and address of person who completed cause of	en 1	210	d. Bo	elline	ole, i	rd-	处12	34.			
4	Sta Registr		31. Date filed (Months Pay Year) 2 2007	strar's Signature	Apo	alle o								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day Year uahes **Physician** ernon 806 06 20 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE Los edal e center FRANKIN Square HOSPITAL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months 1**⊠**M 2□F 88 Yrs. 2-18-1919 MARYLAND Director 218-03-3631 Usual Residence of Decedent 10d Inside City Limits with the Maryland s 23a or 28a-f show rust be notified at 10c. City, Town or Location 10a. State 10b. County 1 □Yes X No ROSEDALE BALTIMORE Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21237 8332 MILDRED AVENUE Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items 11. Marital Status Black, White, etc. within 72 hours after 1 □ Never Married 2 □ Married WHITE 1 ☐ Yes 2 🎇 No 21215-0036 "natural", or If Yes, Give Year or Dates 1942-45 ģ 3 Wildowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education (Specify only highest grade completed) ANCHOR POST I Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) FENCE COMPANY MACHINIST permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: if item 27 is marked other the any injury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be (SANFT) ANNA HUGHES GEORGE Political Polit ဂ 19a. Informant's Name/Relationship (Type. Print) KATHLEEN DIEFENBACH/DAUGH. 5524 EDWIN CT 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Baltimore, 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State GARDENS OF FAITH 6-23-2007 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityCVACH/ROSEDALE FUNERAL HOME 21237 1211 CHESACO AVE ROSEDALE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Pheamonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (uisease or irijury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760. physician Physician/Medical IF FEMALE asn 23d. Date of delivery 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 2 ☐ Fetal death 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Day for 1 in the past 12 months? 5 Other (specify) ☐Yes 2☐No P.O. 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform 2 3 No 1□ Yes certificate Division or Vital the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Impatient 3□ DOA 2 □ ER/Outpatient Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 1 Natural After Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death.

Director: / 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in 24 hours.
the Funeral Directory filled in by determined 4 ☐ Homicide Tectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

HuT: DEBRA 31. Date filed (Moith, Day, Year)

29b. Signature and title of certifier

9000 FRANKIIM SQUARE PRIOR PALTIMORE 32 strar's Signature

MD

30. Name and address of person who cheef eted cause of death (Item 23a) (Type, Print)

OPHINAL

29c. License number

DO062573

29d. Date signed (Month, Day, Year)

the

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07-04645 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Evalyn Johnson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Johnson Medical Examiner June 18, 2007 Evalvn 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Bayview Medical Center Raltimore NA 5. Social Security Number If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min Months Days Hours Director 5-14-1954 216-62-6690 M 2 X F Yrs Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 23a or 28a-f shov notified at once. or 28a-f show Md Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21215 2500 W. Rogers Ave. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, or items must be 1 Never Married 2 Armed Forces? White, etc. Married Yes f Yes, Give Yea Yes 2 X No specify: Specify: Black Widowed Divorced Examiner other than "natural", ξ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed more, MD 21215-0036
Pages 1 and 2 should be filed within 72 h
nent of Health and Mental Hygiene Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Disabled NΔ 12th grade 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) marked æ Rudolph Williams Evangelene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Markeeda Gwaltney 1617 E. 30th Street, Baltimore, Md. Daughter 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition other crematory or other place) Burial 2 XCremation 3 Removal from State 6-22-07 Greenmount Cem. Baltimore, Md. mportant Donation 5 Other Specify: ö 22. Name and Address of Facility 21. Signature of Funeral Service Licenses March F.H. East 1101 E. North Ave., Baltimmore, Md C 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line. /Medical Mixed drug intoxication (morphine, oxycodone and citalopram) Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical AMENDED 27,28a-f, perME, g869, 7/10/07 TT X UNPENDED the attending physician ed for use as the burial 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ð Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? ✓ Yes 2 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be examiner? Hospital: 1 Other 4 Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 1 V Yes 2 28a. Date of Injury (Month, Day,Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 1 Natural Yes 2 X No Pending unk the Fnd 6/18/2007 | Fnd 6:52 am 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be Suicide or Town, State determined found in residence (Specify) Homicide 29a. Certifier

Time of Death

0801 hrs

Md.

10d. Inside City Limits

1 X Yes 2 No

21202

Day

Approximate Interval

Between Onset and

Death

Year

2 Nο

Country)

1 🗸 Yes 28f. Location (Street and Number or Rural Route Number, City within 24 hours a 5009 Frankford Ave. Baltimore, MD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. June 19, 2007 Diasse assa Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State Registra

DHMH 17 Rev 1/2001 **OCME 2006** 

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death A 2. Date of Death Physician /Medical 4b. City, Town, or Location of Death Examiner Birthplace (State or Foreign Count(V)) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, **Funeral** Months Days 1 M 2 F Director Residence of Decedent 10d. Inside City Limits 10b. Cour permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and "lental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ØYes 2 □ No Director 10g. Citizen of What Country 10f. Zip Code Funeral 14. Race - American Indian, Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, tc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify. δ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Be ဥ 20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a cons yuence of): **Examiner** Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner the burial-trar Due to (or as a consequence of): certificate has been signed by the attending p rector, page 2 should be detached for use as: IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6-406ther (Specify) 1 Yes 2 1€ No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Division or Vital Records, P.O. Box 68760,

Maryland 21215-0036

Baltimore,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, F.

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of cortifier

31. Date filed (Month, Day,



and manner stated

Charle St. falts. And 2:20 x

29c. License number

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) June 16,2007 Year 11:20 PM **Physician** Charles Allen Kennedy /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baldwin Dulaney Valley Assisted Living Home Hmore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 AM 2 ☐ F **Funeral** May 12, 1946 Days Hours West Virginia 61 218-44-9849 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 10a State 1 □Yes X No Parkville MD Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21234 3029 Second Avenue Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status Black, White, etc 1 Yes 2 Yes If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married White 1 ☐ Yes X ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) EZ Storage Elementary/Secondary (0-12) Manager 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNKNOWN Peggy Harry Kennedy ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 3029 Second Avenue-Parkville, Maryland 21234 Mary Cromwell-spouse 20b. Place of Disposition (Name of EVANS TUNERAL THAPEL 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ②Acremation 3 ☐ Removal from State Forest Hill,MD AND CREMATION-Belair 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 8800 Harford Road Parkville, MD 21234 21. Signature of Funeral Service Licensee EVANS EUNERAL CHAPEL AND CREMATION SERVICES marae 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastasis Coton Cancel Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Munknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be ASSISTED Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide

Physician /Medical **Examiner** 

within 72 hours after death with the Maryland

3altimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

attending physician and for use as the burial-transit ed by the a detached f has page 2 after death.

Director: After this certific in by the funeral director, To the Hospital o within 24 hours aft To the Funeral DI completely filled in Medical

The law requires that the death certificate be executed

P.O. Box 68760,

Division or Vital Records,

the Hospital or Attending Physician:

4 ☐ Homicide

29b. Signature and title of certifier

29a. Certifier

(Check only one)

6 Could not be determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

Rd Balt. MD 21234

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

314 32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

			. For	State of Maryland				Mental Hy	giene	1 (1 7	202	) 2 2
		1	State Registrar		Cei	rtificate of L	Death		Reg. No. 💪 👢	UL		
2 .	hysicia		1. Decedent's Name (First, Middle, Las					2. Date of De Month	Dav	Year	3. Time of [	Death P <sup>M</sup>
	/Medic	al		Kopenhaver	-	4b. City, Town, or	Location of Doath	June 12		y of Death	7:20	P"
	xamin	er	4a. Facility Name (If not institution, give			Takoma P	_			gomer	V	
	n a val		Washington Advent		ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da	th		olace (State or	Foreign
	neral ector			□M 2X)F	Yrs.	Months Days	Hours Min.		2, 1918		ginia	
p		-	Usual Residence of Decedent	10c City	. Town or Lo	ecation					10d. Inside Cit	y Limits
laryla	shov ed at	-									1 ☐ Yes	2 <b>X</b> No
the M	28a-f notifia	rect	Maryland   Prince (	seorge's   Cne	everly	10f. Zip Code			10g. Citizen of	What Cou	ntry?	
with	3a or	Ö	2411 59th Place			20785			U.S.	Α.		
death	r mus	Funeral Directo	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 14. Ra Bla	ace - Americack, White,		
after	or ite		1 Never Married 2 Married	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 ☐ Yes 2 📉 No	Specify:			ify: Whi	te	
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene.	tural", al Exa	d by	3 ☑ Widowed 4 ☐ Divorced  15. Decedent's E		16a. Dece	dent's Usual Occup	ation		16b. Kind of I			
<b>15</b> -	edic	Completed	(Specify only highest gra	ade completed)	(Give life.	kind of work done of DO NOT use retired	during most of wor d)	king	11			
212 x with yiene.	r thar	mo.	Elementary/Secondary (0-12)	College (1-4or 5+)	Hom	emaker				Home		
		3e C	17. Father's Name (First, Middle, Last				18. Mother's Nam					
aryland should be fand Mental I	Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	To Be	Samuel Hugh All		1		Effie F				in Codo)	
Maryland nd 2 should be file lith and Mental Hy	raum raum		19a. Informant's Name/Relationship			ng Address (Street				i, Siale, Zi	p code)	
e, F 1 and Health	em 27		Wayne Kopenhave  20a. Method of Disposition			59th Pla osition (Name of ematory or other place		erly, M	20c. Location	- City or T	own, State	
nor ages ant of	t: If le y or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Denation 5 ☐ Other (Speci			on Cemete	1	6/07	Mt. Ja	ckson	, VA	
Baltimore, permit. Pages 1 ar Department of Hea	Important: If Item 27 Is marked any Injury or other traumatic ev once.		21. Signature of Funeral Service Lice			2. Name and Addre						
Deg a	any one		2 Lennie	Illmin		5997 Main	St., Mt.	Jackso	n, $VA$	22842		
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	iplications that caused the death y one cause on each line.	h. Do not en	ter the mode of dyir	ng, such as cardiad	or respiratory a	arrest,		Approximate Interval Bett Onset and I	е weeп Death
	sician	Ì	Immediate Cause (Final disease or condition	a Aspiration l	Pneumo	nia						
	edical miner		resulting in death)	Due to (or as a consequent	uence of):							
11.2		er	Sequentially list conditions, if any, leading to immediate	b. Hypoxia  Due to (or as a consequence)	uence of):							
uted	ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	С								
O,	an an rial-tr	Exa	resulting in death) Last	Due to (or as a conseq	uence of):							
I Records, P.O. Box 68760, The law requires that the death certificate be executed	hysician and the burial-transit	lical		_d								
ertific	attending ph for use as t	Physician/Med	IF FEMALE:	23c. If yes, outcome pf pregna	ancv				234 [	Date of deliv	verv	
.O. Box the death cert	attend for us	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	al death 3	□Ectopic pregnanc □ Other (specify) _	y			Month		Year
o <sup>å</sup>	y the sched	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown								
S that	been signed by the should be detached	by Pi	Part II. Other significant conditions		ulting in the	underlying cause giv	ven in Part I.		tobacco use co			
ord:	en sig ould b	ed b	Urinary Tract In	fection				1	Yes 2X No	3 □ Pro	obably 4 🔲	Jnknown
Records,	2 8	Completed	Left Adrenal Mas	s				24a. Wa aut	opsy	prior to c	topsy findings completion of c	available ause of
<u>م</u> ۽	page	Con	Hypertension					1□ Yes		death? 1 ☐ Yes	2 No	
or Vital Physician:	After this certificate hat funeral director, page	Be	25. Was case referred to medical examiner?	Hospital:	150/0	Ott	hor:	ath (Check only		Dub /O	-16.3	
OF	r this ral dir	년 2	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time	of 28c. Inju	4 Li Nursing i	Home 5 Res	how injury occ		city)	
Vision Attending	: Afte	tion	1 Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year) on	Injury		rk? ]Yes 2∐No					
Division of Attending	ector by the	ifica	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ome, farm, s	treet, factory, office			(Street and Nu own, State)	mber or Ru	ıral Route Nun	nber,
Di tal or	al Dir	Certification:						1				
Hospi 4 hour	To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Ex	Physician: To the best of my kno aminer: On the basis of examine	owledge, dea ation and/or	ath occurred at the t investigation, in my	time, date and place opinion, death occ	e, and due to th curred at the time	e cause(s) and e, date and plac	manner as e, and due	s stated. e to the cause(	s)
the h	mplet	Med	29b. Signature and title of certifier	and manner stated.		29c. Licen	se number		29d. Date sig	ned (Mont	h, Day, Year)	
<u> </u>	F 8		MA	- M.D		D591	los		6/14	[.o/		
	15		30. Name and address of person wh	o completed cause of death (Ite	m 23a) (Type	e, Print)			_ ( ' ')	417		
	10		Tasneem Malik. N	4.D. 7600 Carr	oll A	ve., Tako	ma Park,	MD				
	St	ate	31. Date filed (Month Pay, 2002)	2007 32 Registrar's Sign								

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

		1 - State Amend Pi, line Registrar  1. Decedent's Name (First, Middle, Las		E, <b>2868</b> , <b>6/2</b>	Milicale of	Death	Page 1 Pa		07 2023
Physic /Medi		FRANCES			KE	HN	Month	Day 2	Year 2007 1606
Exami		4a, Facility Name (If not institution, give Bayview Hospital	street and number)		4b. City, Town, o	or Location of Death Baltimore		4c. County	of Death
Funeral Director			ex 7. Age	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth	/1928	9. Birthplace (State or F
land ow		Usuat Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City I
e Man Sa-feh Liffed	ctor	MD Balti	more	Baltimor	е				1 ☐ Yes 2
ath with th 23a or 26 ust be no	ral Dire	10e. Street and Number 1605 Dundalk	Avenue		10f. Zip Code 2122	22	1	0g. Citizen of 'USA	What Country?
be filed within 72 hours after death with the Maryland that Hygiene. Ind other than "naturel", or terms 23a or 28a-f ehow event, the Modical Examinar must be notified at	1 by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Wildowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	5	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ NO	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Bla	e - American Indian, ck, White, etc. y: White
of 2 should be filed within 72 hours at d 2 should be filed within 72 hours at th and Mantal Hyglene. I? I e marked other than "naturel", or traumatic event, the Modical Exert	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retire facturing	during most of work d)	ing	16b. Kind of B Factor	usiness/Industry Y
uld be filed within Aental Hygiene. rked other than ' tic event, the Ma	To Be Co	17. Father's Name (First, Middle, Last) Joseph F. Armstro	ng			18. Mother's Nam Albina A	e (First, Middle,	Maiden Suman	ne)
s 1 and 2 should be f Health and Mental Itsm 27 le marked other traumatic ev	1 1	19a Informant's Name/Relationship (7 Albina Kehn/Daught	Type, Print) Ler	19b. Maili <b>160</b> 5	ng Address (Street Dundalk	and Number or Run Avenue D	al Route Number undalk,	MD 212	State, Zip Code) 22
permit. Pages 1 an Depertment of Heal Importent: If Itsm 2 any njury or other once		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		20b. Place of Dispo cemetery, crei Chesapea	esition (Name of matory or other pla ake Crema	tory Inc.	වීතික 6 2007		City or Town, State 11e, Maryland
permit. Depertu Import any inj		21. Signature of Funerat Service Licen	soo Retter Mé			antaTomera Pastures			e, Maryland 21
Physician /Medical		23a. Part1. Enter the disease, or come shock, or heert failure. List only of the third that the cause (Final disease or condition resulting in death)	one cause on each line	ATORY T	er the mode of dyi	ng, such as cardiac	1	est,	Approximate Interval Betwee Onset and Dea
Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. ASPIRA Due to (or as a	consequence of):  Tion of consequence of):  cancer with		ions	DATS  MAPPROVED BY M	EDICAL EXAMINE	7 Hours
eath certificate be executed attending physicien and for use as the burial-transit	edical E		d	consequence or).		CERTIFICATION	100		
2 a D	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	у		te of delivery enth Day Yea				
The law requires thet the ate bes been signed by the page 2 should be deteched.	ed by Pt	Part II. Other significant conditions or	ontributing to death but	not resulting in the u	nderlying cause giv	ven in Part t.	23e. Did to		ribute to the cause of deat
: The law re cate hes be , page 2 sh	Complet						24a. Was a autops perford	med?	Were autopsy findings ava prior to completion of caus death? 1 🗌 Yes 2 🗆 No
sicien certifi irector	o Be	25. Was case referred to medical examiner?	Hospitat:	2 - 50/0	Ott	26. Place of Deat	111		
Attending Physicien: r death. ector: After this certific by the funeral director,	atlon: To	27. Manner of Death  1 Matural 5 Pending 2 Accident investigation	28a. Date of tnjury (Month, Day		f 28c. Injui	4   Nursing Ho	ome 5 Residence 28d. Describe he		
To the Hospital or Attending Physicien: The is within 24 hours after death.  To the Funerel Director: After this certificate he completely filled in by the funeral director, page?	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At home, farm, str (Specify)	reet, factory, office		28f. Location (Si City or Town		er or Rural Route Number
the Hospital or in 24 hours atte the Funeret Dir pletely filled in I	Medical	29a. Certifier 1 V Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of niner: On the basis of e and manner state	ixamination and/or in	h occurred at the til vestigation, in my o	me, date and place, opinion, death occurr	and due to the c red at the time, d	ause(s) and ma ate and place,	anner as stated. and due to the cause(s)
To the within 2 To the complete	2	29b. Signature and titte of certifier	m. M.	m.0	29c. Licens			_	d (Month, Day, Year)
(0)		30. Name and address of person who o	completed cause of dea	ath (Item 23a) (Type.		5-000		TUNE	2,2007
		Dr. Kristi Mizelle	4948 EASTE	EN AVE BA	1 TI MORE	MARYL	AND 212	-24	
St Regist	ate rar	31. Date filed (Month, Day, Year)  JUN 2 0 201	37 Registrar	's Signature	ale	, ,			

07-04625

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

lerry Lyeli	1- For State of Maryland / Department of He 1- For State Certificate of De	oth	2007 2023
Physician/	Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of Death	3. Time of Death
Medical Examiner	0-2-7	June 17, 20 y, Town, or Location of Death	307 1225 HIS
()	4a. I don'ty Harrie (ii not institution, give other and	napolis	Anne Arundel
Funeral Director	354-68-9658 1X M 2 F 37 Yrs.	The state of the s	N(MM/DD/YYYY) 9. Birthplace (State or Foreign Country)linois
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
nd show a	Illinois Williamson Johnston C:		1 X Yes 2 No
vith the Maryland s 23a or 28a-f sh. e notified at once ral Director	10e. Street and Number 10f.		g. Citizen of What Country? U.S.A.
ith the adding an ordific	601 W. 4th Street  11. Marital Status  12. Was Decedent Ever in U.S.   13. Was Dec	52951  edent of Hispanic Origin? (Specify Yes or No-	
er death v , or item r must b	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes	ecify Cuban, Mexican, Puerto Rican, etc.)  2 No specify:	White, etc.  Specify: White
iours aft	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Us during most of	ual Occupation (Give kind of work done working life, DO NOT use retired)	16b. Kind of Business/Industry
5-0036 ed within 72 hour lygiene. other than "nature Medical Exan	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Paint	er	Bridge Painting
5-00; ed with lygiene other t	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle, N	Maiden Surname)
1215 d be fill lental H arked arked vent, t	Jesse Franklin Lyell	Elaine Hayes	her City or Town, State, Zip Code)
MD 21215-0036 ad 2 should be filed within 7 thth and Mental Hygiene. n 27 is marked other than aumatic event, the Medica To Be Comple	James A. Lyell (Brother) 11700 Ha	ress (Street and Number or Rural Route Num rmony Church Rd., Fra	West nkfort, IL 62896
sges I and 2	20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State Herrin City	ace)	20c. Location - City or Town, State Herrin, IL
Baltimore, permit. Pages I ar Department of Her Important: If ite injury or other tr	4 Donation 5 Other Specify:	and Address of Facility an & Wilson Funeral H W. Broadway, Johnston	ome City, IL 62951
Physician	23a Part). Enter the disease, or complications that caused the death. Do not enter the month of the cause on each line.	de of dying, such as cardiac or respiratory arre	est, shock, or heart Approximate Interval Between Onset and
Medical	Immediate Cause (Final disease or condition resulting in death)  a. Methadone intoxication  Due to (or as a consequence of):		Death
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		
uted da ansit	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.		
60, ate be executed hystician and te burial - transit Medical Ex	XUNPENDED AMENDED #23a,PII,27,28a-f, perME, s	868, 6/27/07 TT	
687 ertific ding p	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal december 12 pregnant at time of death 15 Other		23d. Date of delivery  Month Day Year
Box he death c	1 Yes 2 No 9 Unknown g Unknown  Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I. 23e. Did to	obacco use contribute to the cause of death?
b, P.O. Bot irres that the decaded by the detached for the both the detached for the both by Physics	Morehina		s 2 No 3 Probably 4 V Unknown
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that it safter death.  **Al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detachtification: To Be Compilated by the contribution.			prior to completion of cause of death?
I Re in The inficate or, page		1 ✓ Yes 26.Place of Death (Check only one)	2 No 1 Yes 2 No
f Vital Physician Pris cert ral directo	examiner? Hospital: The start of FRIO tradical 3	DOA Other Nursing Home 5	Residence 6 Other: Scene
Ing Pt	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	1 Vac 2 No	how injury occurred
Sior Attend r death ector: by the	Pending Investigation 28e. Place of Injury - At home, farm, street, fa	ctory office building etc. 28f Location (	Street and Number or Rural Route Number, City
Division of Vital Rec ppital or Attending Physician: The cours after death.  The rearl Director: After this certificate filled in by the funeral director, page	3 Suicide 6 X Could not be determined (Specify) found in hote	or Town, S	State) Extended Stay America  Dr. America
Division  To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the 1	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred cone)  2 Medical Examiner: On the basis of examination and/or investigation, and manner stated.	at the time, date and place, and due to the caus	se(s) and manner as stated. and place, and due to the cause(s)
1 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.	June 18, 2007
10	Patricia Aronica-Pollak MD. Assistant Medical Examiner 11	1 Penn Street, Baltimore, MD 2120	)1
Stat Registra	and a second sec		
DHMH 17 Rev 1/200	and the following of the property of the prope		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 23a, PtI, II, 25 per ME G868, 96/21/07dhb

Reg. No. Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Jane S. Lissau 5:55 AM  $f \infty S$ /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth June 3, 1924 5. Social Security Number 7. Age (In yrs. last birthday, 83 Yrs. 9. Birthplace (State or Foreign **Funeral** Days Hours Months Mary Pand 1 □ M 2 X F 218-12-3669 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. Count 10d. Inside City Limits r 28a-f show notified at Maryland N/A Baltimore 1 XYes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ral", or items 23a or Examiner must be 3114 Pelhan Avenue 21213 USA permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hyghene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic acces. Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Reinhard Margaret Schliski 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Lissau/Husband 3114 Pelhan Avenue Baltimore Marvland 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Elkridge Maryland Meadowridge Mem. Park 6/11/07 4 Donation 5 Other (Specify) 22. Name and Address of Facility 5305 Harford Road In Baltimore Maryland, 21. Signature of Funeral Service Licenses mixue los 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** HMOXI disease or condition resulting in death) /Medical Due to (or as a consequence of): Metabolic Abnormalities Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (of as a consequence of) Examine The law requires that the death certificate be executed burial-transi 110 per and resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No ed by the atter 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension, Alxheimer's Disease 1 Tyes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 1 21 No Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 3□ DOA ပ 1 ¥ Yes 1 Impatient 2 ☐ ER/Outpatient filled in by the funeral 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Prospital or Attending P 24 hours after death. Funeral Director: After t After 1 Certification: Injury 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 [Ycertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

JUN 2 1

Registrar

DHMH 17 Rev 1/2001

07-04672 Jeffrey Lonev

Me

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2007 20236

y Loney	1-	For State	State of maryians	Certificate	e of Death			Reg. No.		Lo Time of Dooth
	Re	gistrar Decedent's Name (Fir	st, Middle,Last)				2. Date of Month	n Day	Year	3. Time of Death 2135 hrs
hysiciar Examin	*	TEE	FEDI		LONE	V	June	18, 2007	Onwahi of Dor	
Examini		a Facility Name (if not	institution, give street and number	er)	4b. City, Town,		Death		c. County of Dea Baltimore Co	
	-	Northwest Hos			Randalist					
	4	. Social Security Numb		Age (In yrs. last birthda	ay) If Under 1 Y			e of Birth(MM	For	Birthplace (State or eign
Funeral	5	. Social Security Number	~	45	Yrs. Months D	ays Hours	Min.	tal. 18	1962	Country) MARILLAND
Director	0	213-70-40	5/ 1×M 2 F					14-10		
		Isual Residence of De	. County	10c. City, Town or	Location					10d. Inside City Limits
, any		0a. State 10b	County		DIVE	:1/11/	C			1 Yes 2 No
nd show	5/	MARVLANA _	BALTIMORE		10f Zip Cod	SVILL		10g. C	itizen of What C	ountry?
Maryland 28a-f show d at once.	201	0e. Street and Number	r	0 .	101. 219 000	21	200		11 < 0	
ith the Maryland 23a or 28a-f sho notified at once.	Director	4/00/0	OLD COUR	T ROAL	)	210	(US	or No-	14 Race - Ar	nerican Indian, Black,
vith t s 238 e not	ᇹ	11. Marital Status	12. Was Decede		13. Was Decedent of If Yes, specify Cu	Hispanic Orig Joan, Mexican,	, Puerto Rican,	etc.)	White, et	э.
or items	Funeral	1 Never Married	2 Married Armed Force 1 X Yes	2 No					Specify: [-	31 DOV
er de		3 Widowed	4 Divorced If Yes, Give Year or Dates:			No specify:		16	. Kind of Busine	ess/Industry
urs af	화	15. Decedent's Educ	ation (Specify only highest grade of	completed) 16a. De	ecedent's Usual Occurring most of working	upation (Give ) life. DO NOT	use retired)	lie liot	,, , , , , , , , , , , , , , , , , , ,	
2 hou "nat	ğ	Elementary/Second					- 0	1	PAIL	RAAA
36 than	힐	12 HIGRA	NF		)ISPA-	T CHE	r's Name (First,	Middle Maid	en Surname)	10/10
5-0036 led within Hygiene. I other that	Completed	17. Father's Name (Fi	rst, Middle, Last)			3.6		/	T	RBV
21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f she marked other than "natural", or items to notified at once e event, the Medical Examiner must be notified at once	Be	FSAA	INER	LONE	Mailing Address (		ELEN	Journal Number	City or Town, S	State, Zip Code)
212 ald be Menta mark	10	19a. Informant's Name	e/Relationship (Type, Print )	19b	Mailing Address (	Street and Nun	mber or Rural R	PIL	15<1111	F MD. 21208
MD d 2 shoulth and 127 is aumatic	-	FFIICI	1 1 1	UIFE) 4	606 OL	O Cou	RT KL	1 120	oc. Location - Ci	
e, MD l and 2 st Health an item 27		20a. Method of Dispo	sition		Disposition (Name ry or other place)	of cemetery,	27	/	6	1.40
F E P		1 X Burial 2	Cremation 3 Removal from	m State	DISON FOR	REST	06-26	-0710	DWING	35 MILLS, MD
Pag ment tant:		4 Donation 5	Other Specify:	LOAN	22. Name and Ad	idress of Facili	X BR	DWAL.	TR. F.	UNERAL HOME
Baltimo permit. Page Department Important: injury or ot		21. Signature of Fund	1 1 1 1 1	Mams	JOS,5	PIMEN	TONA	VE.X	BALTO	MO21211
		Lunu	disease, or complications that call	used the death. Do no	t enter the mode of o	lying, such as	cardiac or resp	iratory arrest,	shock, or heart	Approximate Interval Between Onset and
ysician		failure. List only	one cause on each line.							Death
/Medical Examiner		Immediate Cause (F		nal Hemorrhage consequence of):						
		or condition resulting	b. Cirrhosis of							
	<u>.</u>	Sequentially list con- if any, leading to imr	ditions, ———	consequence of):						
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/	[all	(Disease or injury the events resulting in d	eath) Last Due to (or as a	consequence of):						
uted I	<u> </u> <u> </u>		d							
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that the death certificate be executed that the death certificate be executed need by the attending physician and dearshot for use as the burial - transit	Medical	IF FEMALE:	23c. If yes, o	outcome of pregnancy			opic pregnancy		Month	Day Year
87 tifica ing p	1/2	23b. Was decedent past 12 months	?		2 Fatal death		ppio pi o g ,		į.	
th cer	sician/	1 Yes 2 N	4		5 Other (Speci	y)				
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici To the Funeral Director: After this certificate has been signed by the attending physicil.	by the funeral director, page		rod to medical				ath (Check only			
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ital o	filled in	1 Natural 2 Accident 3 Suicide 4 Homicide	determined (Specify		1 - 1 41-	time data an	d place and du	e to the caus	e(s) and manne	r as stated.
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	tely f	29a. Certifier 1	Certifying Physician: To the be Medical Examiner: On the basis	est of my knowledge,	death occurred at the or investigation, in m	y opinion, deat	th occurred at the	ne time, date	and place, and	due to the cause(s)
thin 2	completely	29a. Certifier 1 (Check only one) 2	Medical Examiner: On the basis	stated.		c. License num			29d. Date sign	ned (Month, Day, Year)
To T	9	29b. Signature	d title of contifier		29				June 19, 2	2007
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3+1		20.11	draps of person who completed ca	ause of death (Item 23	a) -	4		0.1001		
Const.		30. Name and add Mary G. R		f Medical Examir	ner 111 Penn	Street, Ba	Itimore, MD	21201		
		and But the day		Registrar's Signature	A					
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	4 100	0.1	54		CINIGINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** June 2007 10:40 PM Alexander LEamon /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8203 Huntwood Court Prince George's Clinton If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Yrs. 216 73 1716 Aug 12, 2005 Director Clinton, MD Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 1 ☐ Yes 2 ☐ No Director Maryland | Prince George's Clinton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö 8203 Huntwood Court 20735 United States traumatic event, the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status e filed within 72 hours after of Hygiene '' or her than "natural", or Itel 1 Never Married 2 Married 1 ☐ Yes 🂥 No Baltimore, Maryland 21215-0036 Specify. Specify: African þ 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 Is marked othu-any injuy or other traumatic event one. Be Pernel1 Leamon Kimberly Price 19a. Informant's Name/Relationship (Type. Print) (Parents) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8203 Huntwood Court, Clinton, MD 20735 Pernell & Kimberly Leamon 20b. Place of Disposition (Name of cemetery, crematory or other place) June 23, 2007 20c. Location - City or Town, State 20a. Method of Disposition 1 XXurial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery | 1011111011, 1021 | 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses MOJZ84 6633 Old Alexandria Ferry Road, Clinton, MD 20735 rita 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) RESPIRATORY Physician /Medical Due to (or as a consequence of): Examiner BRA, NSTEN Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit BRAID TUMOR Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, certificate has been signed by the attending physician rector, page 2 should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ເ≝No 24a. Was an performe after death.

Director: After this certifice 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred XX Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00022284 ROOP

Registrar

DHMH 17 Rev 1/2001

X

31. Date filed (Month, Day, Year)

III MICHGALAVE NO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

cumc,

3. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Margaret Elizabeth McDonald 2007 550 15 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Ralp Dital N/A f Under 1 Year 8. Date of Birth (Month, Day, Year) Feb. 20, 1921 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** 1 □ M 2 🖁 F Days Country) Maryland 234-38-8336 86 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Hear 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Baltimore City 1 XYes 2 No Maryland N/ADirector 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 3045 Mathews Street 21218 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Home Maker Own Home 12 N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edith May Price Frederick Joyce Lowe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3045 Mathews Street Baltimore, Maryland 21218 Ms. Paula J. Wilson (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20 Evans Funeral Chapel 0 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Peaceful Alternatives Funeral&Cremation Ctr,P.A. 2325 York Road Timonium, Maryland 21093 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical r as a consequence of) Failure Examiner Kenal Sequentially list conditions, if any, leading to find editate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine be executed and Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) ed by the a P.0. 9☐Unknown 9 Unknown been signed b should be deta Part JJ. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 4 Unknown OSTOMY L 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed Yes 2 Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific.
completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) No No 1 Inpatient 2 ER/Outpatient 3 DOA P 1 ☐ Yes 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital or 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PATEL MD SINAL HOSPITAL OF BALTIMORE, MARYLAND.

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Ban Year) 2

32. Registrar's Signature

Patrat Known as Irene Mauer Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, 5

		Please Type or Print in I				-	_		
	1	State of Marylar 1 - State Amend #19a, perFH,g868, 6/22/07		epartment of H Certificate of L		ntal Hygiene Reg. No	2007	20239	
		1. Decedent's Name (First, Middle, Last)			2.	Date of Death Month Da	y Year	3. Time of Death	
Physicia /Medic	_	IRENE MARY MAUE	3			June 17	7 2007	1237 M	
Examin	_	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	40	. County of Death		
		Sinci Hospital of Baltin	last hirthe	Baltin	If Under 24 Hrs. 8.	Date of Birth	a Rinth	place (State or Foreign	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs.	. iasi birtird Yrs	Months Davs	Hours Min.	(Month Day Year	ido MAR	ntry)	
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Ba-f s	Director		ALTIC	3sor		40-0	V		
a or 2		10e. Street and Number		10f. Zip Code	1.0	Tog. Ci	tizen of What Cou	nuyr	
ns 23	eral	11. Marital Status 12. Was Decedent Ever in U	J.S.	13. Was Decedent of H	ispanic Origin? (Specifi	v Yes or No-	14. Race - Ameri	can Indian,	
r iter	Funeral	Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 1 No		13. Was Decedent of H If Yes, specify Cuba		an, etc.)	Black, White,	, etc.	
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shou ind M imar umat	-	19a. Informant's Name/Relationship (Type. Print)	1	Mailing Address (Street	and Number or Rural R	loute Number, City	or Town, State, Zi	p Code)	
and 2 alth a 27 Is or tra		K. Barbara Lutz	7416	2×11/1/1/20	AVE BAI	Timore!	JARAPE	the aide	
of He fitem		20a. Method of Disposition 20b.  ↑★ Burial 2 □ Cremation 3 □ Removal from State	Place of D cemetery,	isposition (Name of crematory or other place	Date		ocation - City or T	own, State	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (Specify)	RKI	2000 12012	150% 300		5Kr.778	( DORTHAR! )	
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13		30. Name and address of person who completed cause of death (lite	em 23a) (T	ype, Print)	w 1 -				
Sta	ate.	31. Date filed (Month, Day, Year) 32. Registrar's Sign	nature	osp. tal of	Baltimer				
Regist		29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Ite  Co-L F. Sloca, MO Since  31. Date filed (Month, Day, Year)  JUN 2 2 2007	A A	CARL!					
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TOUGHT B. PURKEY, D. PURKEY, D. PURKEY, D. PURKEY, D. P. P. S. 2004, 7-15 P. W. STORM STATES AND CONTROL OF THE PURKEY PROPERTY OF THE P	SICI	 an	Decedent's Name (First, Middle, Last     Robert B. Maxey,					2. Date of De	Day	Year 7.15 PM		
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Immediate Cause Final disease or condition   a.   SEPS S   Due to (or as a consequence of):			27 Pa 11. Inter the disease, or comp	lications that caused the de	ath. Do not ente	er the mode of dyin	g, such as cardia	ac or respiratory a	rrest,	Approximate		
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Sequentially list conditions   Sequentially list conditions   Sequentially list conditions   Sequentially list conditions   Sequentially list conditions   Due to (or as a consequence of):			resulting in death)	u			1	1) .				
FFEMALE: 23b. Was decedent pregnant with past 12 months?   1			Sequentially list conditions,	D				11/1	THINER			
FFEMALE: 23b Was decedent pregnant the past 12 months?   1		ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):		U.	L WW - BAN	EDICAL EDICAL			
FFEMALE: 23b. Was decedent pregnant with past 12 months?   1		хап	that initiated events		equence of):		4	WAPPROVEDO				
FFMALE: 23b. Was decodent pregnant in the past 12 months?   1   1   1   1   1   1   1   1   1				d	,							
1   Yes   2   No   3   Probably   4   Munknown		edic		0								
1   Yes   2   No   3   Probably   4   Munknown		nysician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	tal death 3 🗌							
25. Was case referred to medical examiner?  1			Part II. Other significant conditions co	ntributing to death but not re	esulting in the un	nderlying cause give	en in Part I.	23e. Did tobacco use contribute to the cause of death?				
25. Was case referred to medical examiner?  1		ed	Quadriplegia,	ardionyopa	.thy			1 🗆	Yes 2□No	3 ☐ Probably 4 ★Unknown		
examiner?  1						· · -		auto perfe	psy prmed? c	orior to completion of cause of death?		
27. Manner of Death		00	examiner?	Hospital:		Othe	or:					
Succident   Succ		H 1			28b. Time of	1 3L DOX	-					
29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  APR 15 2007  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		Ö		01/20/2007				Sub jed	ct tripp	ed and fell		
29a. Certifier (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  APR 15 2007  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		1 2 1	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At		28f. Location (	Street and Numb					
29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  APR 15 2007  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		ificat			any)			Lexing	gton Str	eet & St. Paul		
29b. Signature and title of certifier  PLS 000  APR 15 2007  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		Certificat	4   Homicide			ce, and due to the	cause(s) and ma	inner as sated.				
May FES 000 APR 15 2007  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			29a. Certifier 1 Certifying Phy			estigation in my of			date and place,			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		edicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	ner: On the basis of exami				, , , , , , , , , , , , , , , , , , ,				
		edicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	ner: On the basis of exami		29c. License	e number		9	d (Month, Day, Year)		
TO DESCRIPT A STEMPTED OF COLUMN VALUE OF THE STATE OF TH		edicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	ner: On the basis of exami		29c. License	e number		9	d (Month, Day, Year)		

#230 Pt II FOLKED TO MA

MAXEY, ROBERT

iadea McDonal	•	State of Maryland / Dep - For State Co	partment of e <i>rtificate of</i>		na Menta		teg. No. 20	07 2024
Physicia	n/	1. Decedent's Name (First, Middle, Last)  KHADEA MCDONALD			•	2. Date of Dea Month	Dav Year	3. Time of Death 0756 hrs
edical Examir		4a. Facility Name (if not institution, give street and number)	4	4b. City, Town, o	or Location of I	June 19, 1	4c. County of De	
		St. Agnes Hospital		Baltimore	1.5.5	000 lo n 1 - 70	N/A	Pidhalasa (Chata a
Funeral Director		5. Social Security Number   6. Sex   7. Age (In yrs   1 x M 2 F	s. last birthday) Yrs.	Months Da		Min.	7. sth(MM/DD/YYYY) 9. Fo	reign MARYLAND
any	-	Usual Residence of Decedent         10a. State         10b. County         10c. Ci	ity, Town or Locati	ion				10d. Inside City Limits
<b>À</b>	5	MD N/A	BALTIMO	ORE CI	ΤY			1 X Yes 2 No
the Maryla a or 28a-f	Director	10e. Street and Number 533 E. 41ST STREET		10f. Zip Code 21	218		10g. Citizen of What C	Country?
death with r items 23	Funeral	11. Marital Status  1 X Never Married 2 Married Armed Forces?  1 Yes 2 X No	If Y			? ( Specify Yes or No Puerto Rican, etc.)	0- 14. Race - Ai White, et	merican Indian, Black, c.
s after ural", o	ক	Widowed 4 Divorced If Yes, Give Yeer     To Dates  15. Decedent's Education (Specify only highest grade completed)	1	Yes 2 X N		nd of work done	Specify:	BLACK ess/Industry
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	ompleted	Elementary/Secondary (0-12)  College (1-4 or 5+)	during m	ost of working li			N/A	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	ပ	17. Father's Name (First, Middle, Last)				Name (First, Middle,		
2121 uld be fi Mental I marked	To Be	KARL MCDONALD  19a. Informant's Name/Relationship (Type, Print )	19b. Mailing	g Address (Str		IA JACKS er or Rural Route Nu	ON imber, City or Town, S	State, Zip Code)
and show		KARL MCDONALD / FATHER						, MD 21218
5   S   S   S   S   S   S   S   S   S		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:	b. Place of Dispos crematory or oth MT . ZI(			Date 6/26/07	20c. Location - Cit	WNE, MD
Baltimo permit. Pag Department Important: injury or of		21. Signature of Funeral Service Licensee	RL 140	Name and Addre	BERTY	HEIGHTS	AVE. BA	HOME 21207 LTIMORE, MD
Physician /Medical		23a Pert I finiter the disease, or complications that caused the destailure. List only one cause on each line.			Contract Con	diac or respiratory ar	rrest, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or didition resulting in death)  a Sudden unexplain  Due to (or as a consequence		n intancy	(SUDI)			Doam
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence	e of):					<del>-</del>
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e of):					
ecuted and - transit	a E	-						
60, tte be exe hysician a e burial -	edic	X UNPENDED #25a, 27, 28a-f,	perME,G870	8/8/07	TI		23d. Date of de	livery
cath certificat eath certificat e attending phy for use as the	ician/M	JENDED #23a, 27, 28a-f, 15 FEMALE: 23b. Was decedent pregnant in the past 12 months? 2 No 9 Unknown 1 Ves 2 No 9 Unknown 2 Unknown 2 Unknown	2 Fe	etal death	3 Ectopic	pregnancy	Month	Day Year
Box the death cryy the attenry hed for us	Phys	1 Yes 2 No 9 Unknown g Unknown  Part II. Other significant conditions contributing to death but no	at reculting in the	underlying caus	e given in Pari	23e. Did	tobacco use contribut	te to the cause of death?
ires that the signed by	ð	Tatil. Other significant conditions contributing to dealing of the contributing to dealing to the contributing to the contribution to the contribu	A resulting in the t					Probably 4 V Unknown
of Vital Records, ng Physician: The law require there this certificate has been si meral director, page 2 should be	Completed					per	opsy prio formed? dea	
1 of Vital Recting Physician: The Land After this certificate funeral director, page	e Co	25. Was case referred to medical		26.Pla	ace of Death (0	1 Yes Check only one)	2 No 1 🗸	Yes 2 No
Vita hysicia this ce	To B	TV res 2 INO	✓ ER/Outpatien			Nursing Home 5		Other:
n of ding P h. After		27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day,Year)  Tod 6 /10 /2007	28b. Time of	1	njury at Work? Yes 2 X I		e how injury occurred	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	ertification:	2 Accident Investigation FTIC 0/19/2007 3 Suicide 6 X Could not be determined (Specific) Found				. 28f. Location		or Rural Route Number, City Baltimore, MD
To the Hospita within 24 hours To the Funera	edical Ce	29a. Certifier (Check only one)  29a Medical Examiner: On the basis of examination	ledge, death occu	urred at the time	, date and plac	ce, and due to the ca	use(s) and manner as	stated.
To 1 To 1	Medi	and manner stated.  29b. Signature and title of certifier			ense number			(Month, Day, Year)
		Patu aronica-Polle	h us	0.	C.M.E.		June 20, 200	7
		30. Name and address of person who completed cause of death (I Patricia Aronica-Pollak MD. Assistant Medica		111 Penn	Street, Bal	timore, MD 212	01	
St Regist	ate	31. Date filed (Month, Ray Year) 2007 32 pagistrar's Sign		W)				

DHMH 17 Rev 1/2001 OCME 2006

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

07-04709 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Pamela Dee Maddux State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year June 20, 2007 0625 hrs Medical Examine Pamela Dee Maddux 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Marv's California 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Foreign Months Days Min. 220 66 8770 Hours Director 2XXF 48 Country) Alabama May 22, 1959 M Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X XNo Maryland St. Marys Leonardtown death with the Maryland Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 22756 Lawrence Ave 20650 United States Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' Never Married 2 Married 2 X No Yes 0 Pages 1 and 2 should be filed within 72 hours after one of Health and Mental Hygiene. Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify. marked other than "natural", c event, the Medical Examiner White 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 15-0036 12 2 Middle Manager Burch Mart 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Gene A. Maddux Be Barbara D. Collins Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 2 Gene A. Maddux (Father) Troy Road, Suitland, MD 20746 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, crematory or other place) Burial 2 X X Cremation 3 Removal from State portant: permit Pag Department Lee Crematory June 22 Donation 5 2007 Clinton, Other Specify 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical ysician a X AMENDED UNPENDED perME 19b perFH. G868. 6/28/07 TT Box 68760, attending physi for use as the bu IF FEMALE: 23c. If yes, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Year Fetal death Month Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 ✓ No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ö ş ₫. 1 Yes 2 V No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No Hospital or Attending Physicians 25. Was case referred to medica 26.Place of Death (Check only one) of Vital Be examiner? Hospital: Other DOA Nursing Home 5 Residence 6 V Other: Scene his Inpatient ER/Outpatient 3 1 V Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🗸 Natural Division e Funeral Director; / - death Pending Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the

Registra DHMH 17 Rev 1/2001 **OCME 2006** 

State

29b. Signafure ar

31. Date filed (Month)

Susan Hogan MD.

Day, Year)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

and manner stated

Assistant Medical Examiner

32. Registrar's Signature

and address of person who completed cause of death (Item 23a)

2007

June 21, 2007

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 30. Name and address

Jack Titus MD 31. Date filed (Month, Day, Year)

person who completed cause of death (Item 23a) Deputy Chief Medical Examiner

ORIĞINAL

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

June 18, 2007

evin Moore		State of Maryland / Depa For State Ce	artment of rtificate of			No. 200	7 20245				
Physiciai Medical Examin	1/	I. Decedent's Name (First, Middle,Last)  DEVIN MOORE	2		2. Date of Death Month	Day Year	3. Time of Death				
Medical Examin		ta. Facility Name (if not institution, give street and number)		city, Town, or Location of Dea	June 20, 20	4c. County of Deatl					
		Johns Hopkins Hospital		Baltimore		N/A					
Funeral Director		5. Social Security Number 2 1 4 0 4 9 7 9 3 6. Sex 17. Age (In yrs.		If Under 1 Year   If Under 24H Months Days Hours M	in.	(MM/DD/YYYY) 9. Bir Forei					
any.	<u> </u>	Jsual Residence of Decedent         10a. State         10b. County         10c. City	, Town or Locatio	n			10d. Inside City Limits				
	5	MD. N/A	BALTI	MORE			1 X Yes 2 No				
ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number		10f. Zip Code	100	g. Citizen of What Cou	ntry?				
ith the		3030 E. MONUMENT ST.  11. Marital Status 12. Was Decedent Ever in U	18 13 Was	21205 Decedent of Hispanic Origin? (	Specify Yes or No.	USA	ican Indian, Black,				
72 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at once	Funeral	1 XNever Married 2 Married 2 Armed Forces? 1 Yes 2 No		s, specify Cuban, Mexican, Puer							
after c	ğ Ā	Widowed 4 Divorced If Yes, Give Year or Dates:		Yes 2 X No specify:		Specify: BLA					
hours "natur		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)		s Usual Occupation (Give kind o st of working life. DO NOT use r		16b. Kind of Business. LINCOLN	,				
5-0036 led within 72 hours after Hygiene. other than "natural", other than "natural",	Completed	GED	HOME :	IMPORVEMENT_		LINCOLN	& SON				
215-0036 be filed within ntal Hygiene. rked other tha ent, the Medic		17. Father's Name (First, Middle, Last)		18.Mother's Na	ne (First, Middle, M	aiden Surname)					
de de de	o Be	ERIC WAGSTAFF  19a. Informant's Name/Relationship (Type, Print )	19b. Mailing	JENN Address (Street and Number of	IFER_HOR r Rural Route Numb	OKTNS per, City or Town, State	e, Zip Code)				
MD nd 2 sho alth and m 27 is	- 4-	JENNIFER HOPKINS (mother)	3030	E. MONUMENT	ST. BAI	TO,MD. 2	1205				
0 8 9 5 5		1 Burial 2 Cremation 3 Removal from State	crematory or other	ion (Name of cemetery, er place)	Date	20c. Location - City o					
Baltimore, permit. Pages I an Department of Her Important: If ite Imjury or other ir	-	4 Donation 5 Other Specify: MT	ZION (			007 BALTI					
Bal perm Depa Impo injur	- 1	160.	GA CA	THE ADDRESS OF FACILITY  SCRU  PRESTO	GGS FUNI	ERAL HOME	21213				
Physician	寸	23a. Part I. Enter the disease, or complications that caused the death failure. List only one cause on each line.	. Do not enter the	e mode of dying, such as cardia	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and				
/Medical Examiner	ĺ	Immediate Cause (Final disease or condition resulting in death)  a. Multiple Gunshot Wou  Due to (or as a consequence)					Death				
	-	Sequentially list conditions,  b.	or).								
	Examiner	if any, leading to immediate Due to (or as a consequence cause. E.ker Underlyk g Cause	of):								
Sit of	Xan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence	of):								
and and	ledical	d. UNPENDED AMENDED									
ar isis	Med	IF FEMALE: 23c. If yes, outcome of pre	gnancy			23d. Date of delive	ry				
Box 6876  e death certificate the attending phy ed for use as the b	cian/	23b. Was decedent pregnant in the past 12 months?		al death 3 Ectopic preder (Specify)	gnancy	Month	Day Year				
Box e death the atte	Physician/M	1 Yes 2 No 9 Unknown 9 Unknown			7						
P.O. B	by P	Part II. Other significant conditions contributing to death but not	resulting in the ur	nderlying cause given in Part I.		2 No 3 Pro	b the cause of death?  Dbably 4 Unknown				
ds, P equires t een sign	sted				– 24a. Was a	n 24b. Were a	utopsy findings available				
e law re has b	Completed	·			_ autops perform 1 ✓ Yes 2	ned? death?					
tal Rec	Be Co	25. Was case referred to medical		26.Place of Death (Che			2 10				
Vit;	2 B	TV res 2 No	ER/Outpatient			Residence 6 Oth	er:				
Division of Vital Records, ral or Attending Physician: The law requir ns after death.  The Director: After this certificate has been sited in by the funeral director, page 2 should be a by the funeral director, page 2 should be a second to be a s		27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month Pass Year) Jun 20, 2007	28b. Time of Ir 1435 hrs	ıjury 28c. Injury at Work?  1 Yes 2 ✓ No	Subject shot	ow injury occurred by police					
/isior r Attend ter death irector: n by the	ficat	2 Accident Investigation	home, farm, stree	t, factory, office building, etc.			Rural Route Number, City				
Divis pital or At ours after d teral Direct filled in by	Certification:	4 V Homicide determined (Specify) Local Stre				ate) h Linwood Street , I					
Division of Vital Records, P.O. Box 68760 within 24 hours after death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physocompletely filled in by the funeral director, page 2 should be detached for use as the b	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
To T To T	Med	29b. Signature and title of certifier		29c. License number		29d. Date signed (M					
		Allena Brassell MA		O.C.M.E.		June 21, 2007					
<i>P</i>		30. Name and address of person who completed cause of death (Ite		enn Street, Baltimore, M	ID 21201						
	ate	Melissa Brassell, MD Assistant Medical Exam  31. Date filed (Month, Pay, Year) 33. Registrar's Signa		enii Sueet, pattiiitore, IV	2 1201						
Regist		JUN 2 2 2007	7. Agen								
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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

- TAGE		1- For State Registrar	or ivial yland / D	Certifica			ivienta		eg. No	200	7 2024	
Physicia edical Exami	an/	1. Decedent's Name (First, Middle,Last	Nas	, h				2. Date of Dea Month	Day	Year	3. Time of Death 0741 hrs	
-	1101	4a. Facility Name (if not institution, give		211	4b. (	City, Town, or L	ocation of D	June 18, 2 Death		County of Death		
		294 Attenborough Drive #2				osedale				Iltimore Cou		
Funeral Director				yrs. last birt	-	Under 1 Year Months Days		4Hrs. 8. Date of Bi		1	thplace (State or nMaryland untry)	
any		Usual Residence of Decedent  10a. State 10b. County	100	: City, Town	or Location						10d. Inside City Limits	
3 2	ō	Md. Baltin	nore	Rose	dale					e e	1 Yes 2 X No	
with the Maryland s 23a or 28a-f show s notified at once.	Funeral Director	10e. Street and Number 294 Attenborou	igh Drive	Ant2		of. Zip Code 21237			•	en of What Cour	ntry?	
n with t ms 23g	erai	11. Marital Status	12. Was Decedent Eve		13. Was D	ecedent of Hisp	oanic Origin?	? ( Specify Yes or No uerto Rican, etc.)			ican Indian, Black,	
e, MD 21215-0036 In and 2 should be filted within 72 hours after death with the Maryland Health and Mental Hygiene item 27 is marked other than "natural", or items 23a or 28a-f short transmatic event, the Medical Examiner must be notified at once retarnmanic.	by Fun	1 Never Married 2 Married 3 Widowed 4 X X Divorced	1 Yes 2  If Yes, Give Year or Dates:	No		s 2 X No		derio Rican, etc.)	s	specify:	White	
hours : natura Exami	ed b	15. Decedent's Education (Specify on	ly highest grade complet	ed) 16a.	Decedent's L during most	Jsual Occupation of working life.	on (Give kind DO NOT use	d of work done e retired)	16b. Kir	nd of Business/I	Industry	
36 hin 72 e. than "	Completed	Elementary/Secondary (0-12) 7 t h	College (1-4 or 5+)		Pres	sman				ing		
5-00 led wit Hygien other		17. Father's Name (First, Middle, Last)						Name (First, Middle,			8	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, th. Medica	Be c	William Nash  19a. Informant's Name/Relationship (T		110	Mailing Ad	drace (Street		na Snyde		or Town State	Zin Codo)	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after next of Health and Modula I lygie weith 75 is marked other than "matural", nor other traumatic event, the Medical Examines.	2	William Nash,									.,Md21237	
re, l s I and f Healt if item er trau	1	20a. Method of Disposition  1 Burial 2 X Cremation 3	Removal from State	20b. Place o	of Disposition	(Name of cem	netery,	Date	20c. Lo	ocation - City or	Town, State	
Baltimore, bermit. Pages I ar Department of Hee mportant: If ite		4 Donation 5 Other Specify:		Bayv							e,Maryland	
Baltimore permit. Pages I Department of H Important: If i		21. Signature of Funeral Service Licen:	see &								al Home,PA d. 21222	
Physician		23a. Part I. Enter the disease, or compl failure. List only one cause on ea		death. Do no							Approximate Interval Between Onset and	
/Medical Examiner	1	Immediate Cause (Final disease a.	Cocaine and		intoxic	ation					Death	
		h	Due to (or as a conseque	ence of):								
	iner	Sequentially list conditions,	Due to (or as a conseque	ence of):								
d sit	Examiner	(Disease or injury that initiated C.	Due to (or as a conseque	ence of):								
30x 68760, death certificate be executed e attending physician and I for use as the burial - transit		X UNPENDED	AMENDED									
760, cate be ex physician he burial	Medical	X UNPENDED							23d.	Date of deliver	l v	
687 certificanding p		23b. Was decedent pregnant in the past 12 months?	1 Live birth  Pregnant at time	of death	Fetal		Ectopic pr	regnancy	\ \ \ \	Month [	Day Year	
	Physician/	1 Yes 2 No 9 Unknown		e or death	Other	(Specify)						
cho th	by PI	Part II. Other significant conditions	contributing to death bu	t not resulting	g in the unde	rlying cause gi	iven in Part f			acco use contribute to the cause of death?  2 No 3 Probably 4 V Unknown		
- S 90 5	ted	Cardiomegaly	<del></del>					24a. Was		-	utopsy findings available	
COFC e law re e has be	Completed							auto	psy ormed?	prior to death?	completion of cause of	
F	e Co	25. Was case referred to medical				26.Place	of Death (Ch	1 ✓ Yes neck only one)	2 No	1 🗸 Ye	es 2 No	
Ivision of Vital I or Attending Physician; after death. Director: After this certif in by the funeral director,	To B	1 ✓ Yes 2 No	lospital: 1 Inpatient		utpatient 3			lursing Home 5		ce 6 🗸 Othe	r: Scene	
n of ding Pi h. After funeral	:uo	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)		Time of Injur		yatWork? ′es 2 XNo	28d. Describe unknowi	-	y occurred		
isio Atten er deatl	icati	2 Accident Investigation	OO - Diese of leive.		d 7:38 arm, street, fa	am		28f Location (	Street an	d Number or Ru	ural Route Number, City	
Div pital or ours after	Certification:	3 Suicide 6 X Could not be determined (Specify) FNd in residence 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 295 Attenber 295 Attenber 295 Attenber 295 Attenber 296 Attenber 297 Attenber 298 Rosedale MD									oorough Dr.	
Division of ' To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Medical (											
	ž	29b. Signature and title of certifier	,			29 c. License O.C.N				ate signed (Mo	nth, Day, Year)	
		30. Name and address of person who c	completed cause of doot!	)		0.0.10	vi. L.		June	10, 2007		
		Ling Li, MD Assistant M	edical Examiner	111 Peni	n Street, I	Baltimore, N	MD 21201	1				
St Regist	ate trar	31. Date filed (Month, Day, Year)	32. Registraris S									
DHMH 17 Rev 1/2	001	0011 2 Z	2007	OR	IGNAL	ele)						

			State	State of Ma	aryland		artment of latificate of		d Mental H	ygiene Reg. No	2001	7 2	12	4
			Registrar  1. Decedent's Name (First, Middle, Last)	1 0	9 .		timouto or		2. Date of	Death			ne of D	eath
_	Physici /Medic	_	William 1-	1. 0	live	R			Month 06	21			:51	$\mathbf{A}\mathbf{M}^{\!\!\!M}$
	Examir	_	4a. Facility Name (If not institution, give s	treet and number)			4b. City, Town,	or Location of D	eath	4c.	County of De	eath		
			117 Fern Drive	7.4-	a (Im rum Iu	4 fo i-46 clove)	Joppa, If Under 1 Year	Maryla If Under 24			Harfor		4-4	F
	Funeral Director		5. Social Security Number 6. Sex	M 2□ F		ast birthday) Yrs.	Months Days		Vlin. (Month,	Day, Year)		Birthplace (S Country)		roreign
			213–28–1367 Usual Residence of Decedent		76_				01/18	/ 1931	Įv	aryla	1a	
-1	yland how	[	10a. State 10b. County		10c. City	, Town or Lo	cation					10d. ins		
2	e Mar a-fsl	cto	MD Harford		Jo	oppa						1 [	]Yes 2	2 <b>X</b> ] No
1	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Cit	izen of What	Country?		
7	ath w s 23a rust t		117 Fern Drive				21085				.s.A.			
-	er de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	<ol> <li>Was Decedent I Armed Forces?</li> <li>1 ☐ Yes 2 X 1</li> </ol>		5. 13.1	Was Decedent of I f Yes, specify Cub	Hispanic Origin ban, Mexican, P	? (Specify Yes or louerto Rican, etc.)	No-	14. Race - Ai Black, W		an,	
7	hours after death with the Maryland hours after death with the Maryland tural", or Items 23a or 28a-f show at Examiner must be notified at	by F	3 <b>K</b> Widowed 4 □ Divorced	If Yes, Give Year or Dates:	NO.		1 □ Yes 2 <b>X</b> No	Specify:			Specify:	White		
- O	2 hou atura cal E	bed	15. Decedent's Educ	ation	- 1	16a. Deced	dent's Usual Occu	pation		16b. K	ind of Busine			
	hin 7.	ple	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5	i+)	(Give life. l	kind of work done OO NOT use retire	e during most of ed)	' working					
T	filed within 72 Hygiene. Arber than "na ent, the Medic	Completed	12			Ste	<u>el Worke</u>				eel_In	dustr		
2	Mental Hygi arked other atic event, t	Be (	17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, Midd	lle, Maiden	Surname)			
9 m	should and Men s marke umatic	၉	William Russell (			T			a Baum					
C 20	12 sho h and 7 is ma trauma		19a. Informant's Name/Relationship (Typ	,		1			or Rural Route Nur.					
-	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Memtal Hygiene.  filed the standard standard hygiene is a standard to the standard other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Robert H. Oliver 20a, Method of Disposition	(son)	20b. PI		Fern Dri sition (Name of matory or other pla		Joppa, M		nd 2 ocation - City	1085 or Town, Str	ite	
7 5	Pages nent of I		1 ☐ Burial 2 ☐ Cremation 3 🕍 Re	emoval from State	- 1	-	-	i i	1001007		•			
1771	permit. Pages 1 and 2 Department of Health s Important: If item 27 is any Injury or other tra		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	e	нідо	gins C	reek Cem	ess of Facility	/26/2007 E. F. La	rtac	gpona,	Tenne	sse	<u> </u>
~ "	permit. Departr Importa any Inju		JE A Xa	sadn					d - Kings					
2			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused	the death						2000	Appro	ximate	een
	Physician	Ш	Immediate Cause (Final disease or condition	sep								Onset	and De	eath
	/Medical	Ш	resulting in death)	Due to (or s	a consequ	- 15								
- 1	Examiner		Sequentially list conditions.	mu	·(+i)	intar	-ct di	ement	ice					
	N. D. is	ine	Sequentially list conditions, law cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ence of	et di					1		
1	and and li-tran	Examiner	that initiated events resulting in death) Last	Due to (or als	a consequ	rence of):	5101							
2760	icate be executed physician and sthe burial-transit	dical E												
8	ificate g phy as the	edic	U.											
Box	leath certific attending p	J/NE	230. Was decedent pregnant	Bc. If yes, outcome 1□Live birth			DEctopic pregnanc	0.4			23d. Date of			
	e deat	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at			Other (specify)			-	Month	Day	Ye	ear
0	Physician: The law requires that the death certificate has been signed by the attending it director, page 2 should be detached for use as	Physician/Me	9 □ Unknown						00 8					
	ires the signed be d	۵	Part II. Other significant conditions con	tributing to death b	ut not resu	iting in the ui	nderlying cause gi	iven in Part i.			use contribute <b>⊠</b> No 3⊟	Probably		
Š	requ	eted									9-			
2 P	has has lee 2 s	Completed							24a. W	as an itopsy erformed?	24b. Were prior death	autopsy fine to completio	lings av	vailable use of
7	ician: The certificate har rector, page		25. Was case referred to medical						1□ Yes	s 21 No		es 2□N	)	
S	sicia s cert irectc	o Be	examiner?	ospital:	nt 2□F	ER/Outpatier	nt 3□ DOA Ot	her:	ng Home 5 YR		6 TOther (6			
Č	g Phys er this eral dir	7: To	27. Manner of Death	28a. Date of Inju	ry	28b. Time of			28d. Describ			респу)		
2	ndling ith. r: Afte e fun	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	y year)	Injury		ork? ]Yes 2 ∏No						
Division or Vital Records	r Attend er death. rector: // by the fi	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injubuilding, etc	ury - At hou	me, farm, str	eet, factory, office	•	28f. Location City or	n (Street ar Town, State	nd Number or	Rural Route	Numb	er,
	ital or rai Dil	Cer			, , ,									
	Hosp 24 hou Fune tefy fil	Medical	29a. Certifier (Check only one) Certifying Phys	ician: To the best	of my knov f examinat	vledge, deatl ion and/or in	h occurred at the t vestigation, in my	time, date and <sub>l</sub> opinion, death	place, and due to to occurred at the time	he cause(s ne, date an	<ul> <li>and manner</li> <li>d place, and</li> </ul>	as stated. due to the ca	use(s)	
	To the Hospital or Attending Is within 24 hours after death.  Completely filled in by the funer.	Med	29b. Signature and title of/certifier	and manner sta	ateu.		29c. Licen	se number	occurred at the tin	29d. Da	ite signed (Me	onth, Day, Y	ear)	
	⊢≯⊨ŏ			Linde	c /	10	100	0439	09	1.		1 -	01	27
			30. Name and address of person who con	mpleted cause of d	eath (Item	23a) (Type,	Print)		1	Ju	ne a	' > ^	_	r
	10			inder.	MD	902	Averill	Rd	Joppa	, M	3 2	1083	)	
	Sta		31. Date filed (Month, Day, Year)	32 Registra	ar's Signat	ure								
	Regist	rar	JUN 2 2 2007	Salato-	, J.	A DA	W.							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2007° **Physician** 1 8 6 Salvatore J. Perrera Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore 3118 Summit Ave. 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/6/1953 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral XX**M 2□ F 53 Maryland Director 220-62-0085 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County at Baltimore 1 ☐ Yes 2 No MD Baltimore 28a-f sh notified Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or 21234 IISA 3118 Summit Ave. Funeral 14 Bace - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2€XNo Specify Specify: white <u></u> 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 27 is marked other than "1 r traumatic event". Elementary/Secondary (0-12) College (1-4or 5+) steamfitter 12 Giant Food 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Salvatore J. Perrera Sr. Kathryn Kane ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) darlene O. Perrera/wife 3118 Summit Ave. Baltimore, MD 21234 item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funera Air Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X IX remation 3 ☐ Removal from State = 5 Department of Important: If any injury or once. 4 ☐ Donation 4 5 ☐ Other (Specify) Forest Hill, 8800 Harford 21. Signature uneral Service License Chapel Parkville, MD Cremation Services 21234 23a. Part 1. Enter the disease, or commercations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Selerosis Amyotrophic
Due (or as a consequence of): Physician y earrs /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examir or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 21 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ပို 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours a ler dear To the Funeral Director completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospitai Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 June 19, 2007 D35012 30. Name and address of cerson who completed cause of death (Item 23a) (Type, Print) North Ave. Bel A.r. Md. 21014 LYNCH Kevin

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

The state of

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** trience ,2007 June /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Maris Baltimore Timonium 4 OSPICE stella 8. Date of Birth
(Month Day, Year) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number **Funeral** 212-56-4975 Days Hours 1 ☐ M 2 💢 F Varyland Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Montal Examiner must be notified at 1 XYes 2 No Baltimore Funeral Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? N. Broadway 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1. Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) aundry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sorothy Moods Baltimore Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Long Green 4 ☐ Donation 5 ☐ Other (Specify) Mr. Zion 22. Name and Address of Facility CHATMON-HOVIS Funeral Home 21. Signature of Funeral Service Licensee ullen Hairs Below Road Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** LUNG CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician Physician/Medical IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐Ectopic pregnancy 1 ☐ Live birth in the past 12 months? 1 ☐ Yes 2 **X** No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 TUnknown Completed 24a. Was an autopsy performed? 1∐ Yes 2**X** No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No After this certificate has or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Medical Certification: To 1 ☐ Yes 2 📉 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA HOSPICE 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death
To the Funeral Director: in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours 29a. Certifier 🜠 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

BEATRICE PRESTON,

2007

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

6/19/07

DR. TARIO MAHMOOD 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only one)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** James Palmer DUK E 08:05 PM 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE HOSPITAL OF BALTIMORE If Under 1 Year | If Under 24 Hrs.

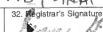
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Months Days X□M 2□F 61 Director 218-44-4148 5-12-1946 Md. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show f Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Md. NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 1313 N. Luzerne Ave. 21213 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give \_ Year or Dates: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled 7th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be fealth and Mental R Rebecca Austin ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) per mit. Pages 1 and 2:9 Der artment of Health au Important; If item 27 is any injury or other trau Angelia Ruffin Daughter 1313 N. Luzerne Ave., Baltimore, Md. Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-22-07 Greenmount Cem. Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East ladu حم 1101 E. North Ave., Baltimore, Md. 21202 an 23a. Part1. Enter the disease, or comp cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final AKLOXIC FRICEPHA BAUK **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner RESPIRATORY 87711S Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed POLY CUBETANCE that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the use as been signed by the attending should be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 No 3 Probably 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 2☐No certificate 2 No 1 □Yes 1∏ Yes Division or Vital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital 🛮 📈 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

SABRIELA



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SZABO, MD, SINAI HOSPITAL OF BALTIMORE

PHOMER

CHANGE

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9	sician		1. Decedent's Name (First, Middle, L	ast)				-		2. Date of De Month			3. Time of Death
	sıcıan edical	1	Jac que lie	25		/~	pour			June	Day I Co	acco 7	200 AM
	miner		a. Facility Name (If not institution, g	ive street and number)			4b. City,	Town, or	Location of Dea			nty of Death	
			Johns Hopkins is	wpiew Co	se C	outer	1301	Here	26		Cal	tron	e Citu
Fune	ral		5. Social Security Number 6.		je (In yrs.	last birthday)	If Under Months		If Under 24 Hr				lace (State or Foreign
Direc	tor		218-48-2652	1□M 200 F	57	Yrs.	Months	Days	Hours Mir	OCT. 2	, 1949	Coun	MD
p ,		-	Usual Residence of Decedent		10.00	-							
aryla shov			10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					1	0d. Inside City Limits
the Marylar 28a-f show	Director	3	MD		BA	LTIMOR	E						1. Yes 2 No
ith th	l id		10e. Street and Number				10f. Zip	Code			10g. Citizen o	of What Coun	itry?
er death with the Maryla tems 23a or 28a-f sho	<u></u>		2815 E. MONUMENT	ST.			212	205			USA		
ir de	Funeral		11. Marital Status	12. Was Decedent Armed Forces?		.S. 13.	Was Deced	ent of His	spanic Origin? (	Specify Yes or Norto Rican, etc.)	o- 14. R	ace - Americ	
36 a afte	7		1 Never Married 2 Married	1 ☐ Yes 2 🔀 If Yes, Give	No		1 ☐ Yes 2			, , , , , ,		cify: BLA	
Ind 21215-0036  be filed within 72 hours after death with the Maryland tal Hygiene.  tal Hygiene.  or teems 23a or 28a-1 show event in Medical English	2	3 -	3 Widowed 4 Divorced	Year or Dates:							, John	2y.	
72 rat	Completed	2	15. Decedent's I (Specify only highest g	Education rade completed)		(Give	dent's Usual kind of work	k done du	uring most of we	nrking	16b. Kind of	Business/Inc	dustry
A high	E	-	Elementary/Secondary (0-12)	College (1-4or	5+)		DO NOT us	e retired)					
lled v	ပ်	3	1 OTH 17. Father's Name (First, Middle, Las	41		NU	RSING		40.14.11.1.11	/= . Ali . II		VATE	
E de la la la la la la la la la la la la la	00	5		1)					18. Mother's Na	me (First, Middle	a, Maiden Sum	ame)	
aryla should I nd Meni	Ę	2	THOMAS PEARSON							STEVENSON			
Maryland d 2 should be file th and Mental Hy 27 Is marked oth	- 33	1	19a. Informant's Name/Relationship			19b. Mailir	ng Address	(Street ar	nd Number or A	ural Route Numb	er, City or Tow	m, State, Zip	Code)
		-	EUGENE RAY, JR.	SON	Jook B				R LA.,	BALTIMOR		21213	
Baltimore, permit. Pages 1 ar Department of Hea Important: If item			20a. Method of Disposition 1   Burial 2 □ Cremation 3	☐Removal from State	200. P	lace of Dispo emetery, crer	natory or oti	e of ter place		Date	20c. Location 11501	GARRIS	wn, State ON FOREST
altim mit. Pagartment ortant:			' 4 ☐ Donation 5 ☐ Other (Spec			GARRI	SON FO	REST	r   6/	22/07			MD 2111
Balti Permit. Departminimporta	once		21. Signature of Funéral Service Lice	ensee	1	22	. Name and	Address	of Facility WI	SLEY CHA	AVIS, J	R. FNR	L. HM.
m %55%	a		Vesley	Chang	2/1	c				AVE., BA			21231
1760, at the be executed we want to be executed with the water and was the burial-transit on burial-transit or burial-transit or the	lcal Examiner		Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Due to or as c. Complicat Due to (or as	a consequi	uence of): uence of): of chron	ic narc	cotian	EMTIFICATION AP	PROVED BY MEDIN	AL EXAMINER		Onset and Death
Box 68 sath certifica attending ph	sian/Med		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 PNo 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	Ectopic pre	gnancy			23d. D	Date of deliver	ry Day Year
Vital Records, P.O. sician: The law requires that the decertificate has been signed by the rector, page 2 should be deached	à		Part II. Other significant conditions	contributing to death b	ut not resu	ulting in the ur	nderlying ca	use given	n in Part I.	23e. Did t	1		e cause of death?
Pecc le lawre has be	0		Bight Above	Mr. Knos	SA	ti co	ches	·	hom	24a. Was		. Were autop	sy findings available
	P		Hamo Tan	1050	220	111	7.0			perfo	ormed?	death?	2□ No
Vital Fision The certificate	Be (	1	25. Was case referred to medical	CAST ICI	6.17	3	.00		26. Place of De	ath Check onl	, -		
of Vita Physician: this certifica	To E		examiner? 1 XYes 2x No	Hospital: Inpatie	nt 2 🗆 1	ER/Outpatien	t 3 🗆 DOA	Other		łome 5 ☐ Resi		ther (Specify	)
	Ë		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Dale of Inju (1. nth, Da)	ry v Year)	28b. Time of Injury	28	c. Injury a Work?		28d. Describe I			
Vision Attending r death. ector: After	atic		2 ☐ Accident investigation	in	, , , ,	injury	М		es 2 🗆 No				
Division  or Attending after death. Director: After	Certification:		3 Suicide 6 Could not I		ury - At ho	me, farm, stre	et, factory,	office		28f. Location (S	Street and Nun	nber or Rural	Route Number,
al or safte	Cert		(	Dullully, etc	. (Specify	,				City of Tol	wn, State)		
Divisio  To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the it.	edical (		29a. Certifier 1 Certifying P (Check only 2 Medical Exa	hysicien: To the best of miner: On the basis of and manner sta	examinat	wledge, death ion and/or inv	occurred a restigation, i	the time n my opir	, date and place nion, death occu	e, and due to the arred at the time,	cause(s) and r date and place	nanner as sta , and due to	ited. the cause(s)
To tl within	ž		29b. Signature and title of certifier				29c.	License r	number		29d. Date sign	ed (Month, D	Day, Year)
			1 WS (2	w	>		E	10C	138	3	June	18, 2	007
09		3	0. Name and address of person who	rough t	<b>I</b> , F	10	T	505	Hepl		gvie		rele
	State strar	3	31. Date filed (Month, Day, Year)	32. Registra	ar's Signat	enut	ري	(1)	11-636	, , , , ,		<del>-7</del>	

friend to with

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician 10:L14AM Harriet Jane Shaw 200t JUNE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Good Samaritan Hospital Baltimore N/A Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F Months Days Hours 88 077-18-4024 Dec. 03, 1919 South Hampton, PA Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location sa or 28a-f show t be notified at 1 ☐ Yes 2 No Maryland | Baltimore County Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1814 Dunwoody Circle 21234 United States permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must to Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 █No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: White 3 ☐Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) University of College (1-4or 5+) N/A Elementary/Secondary (0-12) Maryland Hospital Director of Volunteer Services 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Fred K. Tewell Lena R. Beck 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. Frederick W. Irvin(nephew) 285 Manchester Street Manchester, PA. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Evans Funeral Chapel 6/18/0 Forest Hill, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Peaceful Alternatives Funeral&Cremation Ctr.,P.A.
2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Lipenses W 23a. Pan J. Uniter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock for hear failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARD TO GENTS HOCK Approximate Interval Between **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed SEVERE HORTIC STENOSIS burial-trar Due to (or as a consequence of): attending physician for use as the burial P.O. Box 68760, GT BLEE DING Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 mopths? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 ☐ Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1☐ Yes 2☐Mo 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2□NQ 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

10

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LANTA RASSEK

56012061+ RAVEN

32. Registrar's Signature

RESOOD

BLVA

JUNE, 13, 2007

GOODSAMARITAN

BALTIMURE MD 27235

			e	State	of Maryl	and / Dep	artment of	Health	and M	lental Hygi	ene	9		
		•	For State Registrar		,		rtificate o				g. No.	0.7	20253	}
			Decedent's Name (First, Middle)	Last)						2. Date of Death	1	V 1	3. Time of Death	
	Physicia /Medic		Helen	Virginia	a		Sims			June 15	, 200	Year 7	8:30 P	vi i
	Examin		4a. Facility Name (If not institution	give street and nu	ımber)		4b. City, Town	, or Location	of Death		4c. Cou	nty of Death		
-			Glen Burnie Reh				Glen If Under 1 Yes	Burnie ar_   If Unde		0.0.1.10.11	Ann	e Arui		
	Funeral Director		5. Social Security Number 235–28–6068	6. Sex 1 ☐ M 2 🛣 F	7. Age (III 82	yrs. last birthday Yrs.	Months Day		Min.	8. Date of Birth (Month, Day,	Year)	9. Birthi	place (State or Foreigntry) Virginia	n
			Usual Residence of Decedent		UZ					Aug. 20	, 192	4 West	- virginia	
	how tat	_	10a. State 10b. County		100	. City, Town or L	ocation						10d. Inside City Limit	
	se Ma 8a-f s	Director	WV Greenb	rier	W	hite Su							1 □ Yes 2 💆 N	0
	vith th	Dir	10e. Street and Number				10f. Zip Code			10	-	of What Cou	ntry?	
	eath v	Funeral	HC 69 Box 70	12. Was Dec	redent Ever	in II S 13	Was Decedent o		rigin? (Sp.	acify Vas or No.	U.S.	A. Race - Ameri	can Indian	_
	r iten r iten iner	Fu	1 ☐ Never Married 2 🗓 Marri	ed 1 ☐ Yes	orces? 2 💢 No		Was Decedent o			Rican, etc.)		Black, White,		
ဗ္ဗ	ours a ral", o Exarr	by	3 Widowed 4 Divorced	If Yes, G Year or I	ive Dates:		1 ☐ Yes 2X N	lo Specify	<i>'</i> :		Spe	ecify: Wh	nite	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hyglene.  id other than "natural", or items 23a or 28a-f show other than "natural", or items 24a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent (Specify only highes		)	16a. Dece	edent's Usual Occ e kind of work don DO NOT use reti	cupation ne during mo	st of work	ing	6b. Kind o	f Business/In	ndustry	
2	within sne. than '	Idu	Elementary/Secondary (0-12)	College	(1-4or 5+)	1		red)			0	II		
N D	filed v Hygie ther 1	ပ္ပို	17. Father's Name (First, Middle,	Last)		НО	memaker	18. Moth	ner's Name	e (First, Middle, N		n Home	2	
a	should be f and Mental H s marked of umatic eve	To Be	James Whitten	Lowe				Ida	Bel.	le Bosti	с			
ary	shou and M s mar		19a. Informant's Name/Relationsh	nip (Type. Print)		19b. Mail	ing Address (Stre	et and Numl	ber or Rur	al Route Number,	City or To	vn, State, Zij	p Code)	10
Σ	and 2 ealth n 27 i		Larry W. Sims	(Son)						ırnie, M	210	61		
ore	- T = =		20a. Method of Disposition 1 ☐ Burial 2 K Cremation	3 □Removal from	State 20	Ob. Place of Disp cemetery, cre	osition (Name of ematory or other p	olace)	ı	Date 2	20c. Locatio	n - City or T	own, State	
Ē	t. Par tmen tant: ijury		4 □ Donation 5 □ Other (Sp		l M	letropol					Alexa	ndria.	, VA	-
Baltimore,	permit. Pages Department of I Important: If ite any Injury or of		21. Signature of Funeral Service	loginsee	1		2. Name and Add Longanac					4 - 117	7 0/070	
	AR CO		23a. Part 1. Enter the disease, or	complications that	caused the					Spg. Ron or respiratory arre		Le, W	Approximate	
	Physician		shock, or heart failure. List	only one cause on	each line.	ATTIA							Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	a. Due to	(or as a cor	nsequence of):		-					O JETK	
	Examiner	.	Sequentially list conditions	b										
1/	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter I Inderlyin, Cause (Disease or injury	Due to	(or as a cor	nsequence of):								
K	xecut and al-tran	Examiner	that initiated events resulting in death) Last	c	(or as a cor	nsequence of):								-
8760,	The law requires that the death certificate be executed ate has been signed by the aftending physician and page 2 should be detached for use as the burial-transit	ical		d										
Ö	tificat ig phy as the	fedi									= 120			
Вох	death certific aftending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, of	utcome pf pr		□Ectopic pregna	ncv			23d.	Date of deliv		- 1
	e dea the af	sici	in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		gnant at time		Other (specify)					Month	Day Year	
Д.	hat the	Phy	Part II. Other significant condition	ens contributing to	death hut no	t resulting in the	underlying cause	given in Part		23e. Did toh	acco use c	ontribute to	the cause of death?	-
Records,	uires that the de signed by the a Id be detached f	d by	The same of the sa	ine continue and to		riodaning in the	andonying oddoo	giveriar	• ••	1 □ Ye			bably 4 Unknov	vn
Ö	w requir been si should I	etec								24a. Was ar			opsy findings availab	
Š	he lav e has	Completed								autops perform	v i	prior to co death?	ompletion of cause of	f
Vital	<b>hysician</b> : The la his certificate ha: I director, page 2	Be C	25. Was case referred to medical					26. Plac	ce of Deat	1  Yes 2 h (Check only one		1 □ Yes	2 No	-
>	nysici iis cer direct	To B	examiner? 1 ∐ Yes 2 🌠 No	Hospital: 1	] Inpatient	2 ER/Outpatie	ent 3 DOA	Othor:		ome 5 Reside		Other (Speci	ify)	
Division or	Attending Physician: r death. ector: After this certifics by the funeral director, I		27. Manner of Death 1 X Natural 5 ☐ Pending		e of Injury onth, Day Yea	ar) 28b. Time Injury	of 28c. Ir	njury at Vork?		28d. Describe ho				
Sio	tendil eath. Ior: A the fu	catic	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	ation				☐Yes 2☐	□No					
$\leq$	I or Attend after death. I Director: /	Certification:	4 Homicide determ	inad   Zot. Flat	ce of injury - ding, etc. (S	At home, farm, s pecify)	treet, factory, offic	ce		28f. Location (St. City or Town		ımber or Rui	ral Route Number,	
	Hospital 24 hours a Funeral I		29a, Certifier 1X Certifyin	g Physician: To th	ne hest of my	v knowledge, dea	th occurred at the	e time, date a	and place	and due to the ca	ause(s) and	I manner as	stated	-
	To the Hospital or A within 24 hours after To the Funeral Directory filled in b	Medical	(Check only 2 Medical one)	Examiner: On the	basis of exa	mination and/or	nvestigation, in m	ny opinion, de	eath occui	rred at the time, d	ate and pla	ce, and due	to the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and title of certifier	him	MI	>	29c. Lice	ense number		2	9d. Date si	gned (Month	, Day, Year)	
			I Wa !				D	5110	Ч		UNE	- 19	2007	-
			30. Name and address of person	who completed car	use of death	(Item 23a) (Type	, Print) VS	MA '	VEA	IULAL	LON	DA		
	Sta	te	31. Date filed (Month, Day, Year)	32.	Registrar's	Signature	NO.	7	124	TIM	ORF	- M	12 212.	26
	Regist		JUN 2 2 7	2007	The s	13. 1998	all s							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

d Item 25 per ue, 366,06721/0/db Cortificate of Death

		4	For Amend State Registrar	Item 25 p	er ue,866	8,06721/	Olamb Dep Ce	artment of H rtificate of L	eaith and iv Death	rientai Hyg	Reg. No. 2	007	20254
	Physicia	20	1. Decedent's Name	e (First, Middle,	Last)					2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	_	Robert C		_			T: -	A Death	05-28-		ty of Death	8:05 P <sup>M</sup>
	Examin	er	4a. Facility Name (li Baltimor				Contor	Glen Bur	Location of Death			Arun	
			5. Social Security N		6. Sex		yrs. last birthday		If Under 24 Hrs.	8. Date of Birtl	h	9. Birth	place (State or Foreign
	Funeral Director		213-36-6	126	1 XM 2□F	68	Yrs.	Months Days	Hours Min.	(Month, Day 03-05		Con	intry) MD
	aryland show	_	Usual Residence of 10a. State	10b. County		10c.	City, Town or L	ocation					10d. Inside City Limits 1 ☐ Yes 2 No
	8a-f	Director	MD		Arunde1		Glen Bu				10g. Citizen o	f What Cou	intry?
	with the	Ē	10e. Street and Nur					10f. Zip Code	<i>C</i> 1				,
	eath is 23	eral	401 Phir	ne ka.		cedent Ever i	n U.S. 13.	Was Decedent of H If Yes, specify Cuba		ecify Yes or No-	U.S.A	ace - Amer	ican Indian,
30	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show with the Medical Examiner must be notified at	by Funeral	1 XNever Marr 3 Widowed		Armed	Forces? s 2 ☐ No Give		If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		Rican, etc.)	Spec	ack, White	hite
12-0036	n 72 hou "natura edical E	Completed			t grade complete	·	16a. Dece	edent's Usual Occup e kind of work done o DO NOT use retired	ation during most of work t)	king	16b. Kind of	Business/I	ndustry
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0	be filed ntal Hyg ed other event, i	Be C	17. Father's Name						18. Mother's Nam				
Ö	uld be Aental rked o tic eve	To B	George T	hurmas	Sparks				Marie A	nne Aug	sburge	r 	
Maryiand	s 1 and 2 should f Health and Men item 27 is marke other traumatic		19a. Informant's N	ame/Relationsh	ip (Type. Print)		19b. Mail	ing Address (Street	and Number or Ru	ral Route Numbe	er, City or Tow	n, State, Z	ip Code)
	and and m 27		Mr. Geor		ks, Jr.			40 Charin		Cockeys	ville,		
ore	0 0		20a. Method of Dis 1 → Burial 2		3 □Removal fro			osition (Name of ematory or other plac					,
<u>=</u>	t. Pag tmen tant: jury			5 ☐ Other (Sp			Cedar H	111 Cemete	ry 06-07	7-2007	Brookl	yn Pa	rk, MD
Baitimore,	permit. Page Department Important: II any injury or once.	rî.	21. Signature of Fi	ans.	wind	SMOI	479	22. Name and Addre	Ave SW; G	len Bur	nie, M		61
	Physician /Medical		23a. Part1. Enter is shock, or hea immediate Cause disease or condition resulting in death)	(Final	a	Cere	bra		Cert				Approximate Interval Between Onset and Death
	Examiner	e.	Sequentially list co	onditions,	b		nsequence of):		CERTIFICATION AS	WW WEDK	AL EXAMINER		
t	xecufed and I-transit	Examiner	Sequentially list co if any, leading to in cause. Enter Und Cause (Disease or that initiated event resulting in death)	erlying r injury s Last	c	to (or as a cor	nsequence of):		TECHTON AP	PROVEDBY			· · · · · · · · · · · · · · · · · · ·
68760,	icate be executed physician and s the burial-transit	edical E			d				CERIII				
.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and over 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2 9 □ Unknowr	2 months? □ No	1 □ Liv	outcome pf pr e birth 2 egnant at time known	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у			Date of deli Month	ivery Day Year
ds, P.	w requires that to been signed by should be detact	by	Part II. Other sign	ificant condition	ons contributing to	death but no	t resulting in the	underlying cause giv	ven in Part I.	23e. Did t	1		the cause of death?
i Records,	hysician: The law rec nis certificate has beel I director, page 2 shou	Completed								24a. Was auto perfo	an 24 psy ormed? 2/1 No	b. Were au prior to death? 1 🗌 Yes	atopsy findings available completion of cause of 2 ☐ No
Vital	clan: ertific ctor,	Be	25. Was case refe examiner?	erred to medical					26. Place of Dea	th (Check only o	one)		
	Physik r this c ral dire	2	1 🙀 Yes 🎘	<del>J No</del>			2 ER/Outpati		4 🗆 ivursing H	lome 5 Resi			cify)
Ĕ	ding F n. After funera	iii	27. Manner of Dea	5 Pendin	g (A	ite of Injury Ionth, Day Ye	ar) 28b. Time Injury	Wo	ryat rk? ]Yes 2∐No	28d. Describe	now injury occ	urreu	
Division or	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, I.	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investig 6	not be 28e. Pl	ace of injury - illding, etc. (S	At home, farm, s pecify)	street, factory, office	103 2 100	28f. Location ( City or To	Street and Nu wn, State)	mber or Ri	ural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only		Examiner: On th	e basis of exa		ath occurred at the ti investigation, in my					
	To the within 2.  To the complete	Medical	one) 29b. Signature an	d title of certifie		anner stated:		29c. Licens			29d. Date sig	ned (Mont	h, Day, Year)
	1 1		30. Name and add	c (dress of person	who completed o	ause of death	(Item 23a) (Typ	05-	1076	0/	5/28	5,6	7
	10		Muncon 31. Date filed Min	n mad	GYAL	DUC 2. Registrar's	SHLY	3251	105 prita	ex ai	11/1C	6	Contracto M.
	St Regist	ate rar	OT. Date light MP	Z. I. 500	Black	A.	Board	ار ا					

DHMH 17 Rev 1/2001

07-04671 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. William Sedgwick State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day June 18, 2007 1940 hrs Medical Examiner WILLIAM O. SEDGWICK 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death County of Death **Baltimore County** Northwest Hospital Center Randallstown 9. Birthplace (State or B. Date of Birth (MM/DD/YYYY) 5 Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** oreign CounMARYLAND Months Days Hours Mir 219-98-6685 Director 3/22/1968 39 1 X M 2 Yrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State BALTIMORE RANDALLSTOWN MD 1 Yes 2 XNo 28a-f show notified at once. with the Maryland 10g. Citizen of What Country? 10e, Street and Number 10f, Zip Code 9539 BRANCHLEIGH ROAD 21133 USA items 23a Funeral 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. must be Armed Forces? death. 1 Never Married 2 X XMarried Yes 2 X No 5 BLACK Yes. Give Year Yes 2 X No specify: hours after Divorced Pages 1 and 2 should be filed within 72 hours after innent of Health and Mental Hygiene.
 Trant: If iten 27 is marked other than "natural", yor other traumatic event, the Medical Examiner. þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) OF SYSTEMS CONNECTIONS SUPERVISOR Baltimore, MD 21215-0036 MD FURNITURE CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM O. SEDGWICK, ZORITA BROOKS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21133 MELANIE SEDGWICK 9539 BRANCHLEIGH RD, RANDALLSTOWN, WIFE 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a, Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 6/23/07 PIKESVILLE, MD DRUID RIDGE CEM. 4 Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licensee HOWELL FUNERAL HOME 21207 dur 4600 LIBERTY HEIGHTS BALTIMORE, MD AVE, Approximate Interval disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and llure. List only one cause on each line /Medical a. Multiple Injuries Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed pue Physician/Medical ruse as the bir LINPENDED AMENDED The law requires that the death certificate be Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death Month Day 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 V No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? page Yes 2 1 V Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Other 4 Innatient 2 ER/Outpatient 3 V DOA Nursing Home 5 Residence 6 Other this 1 V Yes No 28a. Date of Injury (Month, Day Year) Jun 18, 2007 After 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27, Manner of Death Operator of motorcycle which struck fixed object 1904 hrs i 24 hours after death.

e Funeral Director: A etely filled in by the fu 1 Natural Yes 2 ✔ No Pending Certificati 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be or Town, State) Branchliegh Rd & Holshire Ct, Randallstown, MD determined (Specify) street Homicide 29a. Certifier

within 2

completely

ical

State

Registrar

29b Signature and title of certifie

31. Date filed (Month, Day Year)

Patricia Aronica-Pollak MD.

DHMH 17 Rev 1/2001 OCMF 2006

Q

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c, License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

June 19, 2007

32 Registrar's Signature

SE MEST CAR .

Assistant Medical Examiner

and manner stated.

30. Name and address of person who completed cause of death (Item 23a)

200

**OCME** 

State Registrar

DHMH 17 Rev 1/2001

Reisterston

MD

6821

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salvia

31. Date filed (Month, Day, Year)

0209260

21215

Balt Mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** AVIS **SYKES** JUNE 2007 0609 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner PRINCE GEORGE'S LAUREL REGIONAL HOSPITAL LAUREL 1 Year | If Under 24 Hrs. If Under 1 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 ☐ M 2 🖫 F 33 Yrs. 227-06-8115 Director 9/18/1969 VIRGINIA Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 ☐ No Director MD PRINCE GEORGE'S HYATTSVILLE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ms 23a or Funeral 7731 NORMANDY RD. 20785 UNITED STATES ral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: ş Specify: BLACK 3 Widowed 4 Divorced "natural", the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC DOMESTIC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NATHANIEL SYKES MATTIE CROCKETT P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MATTIE SYKES/MOTHER 2202 AFTON AVE., RICHMOND, VA. 23224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State al a Cremation 1X Burial ☐Removal from State 4 □ Do 5 Other (Specify) OLIVET CEMETERY 6/15/07 WASHINGTON D.C. 22. Name and Address of Facility 21. Signa , Funeral Service CAPITOL MORTUARY 1425 MARYLAND AVE., 23a. Pa 1 . Enter the disease, o shock, or heart failure. Lis enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** END STAGE AIDS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner CNS TOXOPLASMOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine The law requires that the death certificate be executed SEIZURE DISORDER that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical ASPIRATION IF FEMALE 23c. If yes, outcome pf pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown has been signed 2 CANDIDIASIS Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a, Was an rector, page 2 1□ Yes 2 🙀 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 3□ DOA ٩ 2F ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Injury 5 Pending To the Hospital or Attendii within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1.X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2. Medical Examiner: On the basis of examination and/or investigation in my opinion death accordance to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier ATTENDIN G 29c. License number 29d. Date signed (Month, Day, Year) D0057216 address of person who completed caus e 9 10 NA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

JUN 2 2 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** Kenneth Theodore Spencer 2007 June 18 10:01 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Upper Chesapeake Medical Center Bel Air Harford Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 ☑ M 2 ☐ F Dec. 26, 1938 213-34-4885 Maryland Director 68 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10h. County ns 23a or 28a-f show must be notified at 1X Yes 2 No Director Maryland N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21224 United States 3922 E. Pratt Street Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? "natural", or items 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Saltimore, Maryland 21215-0036 Specify: White à 3 ☐ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: if item 27 is marked other than "n any injury or other traumate. College (1-4or 5+) Elementary/Secondary (0-12) Railroad/Maintenance 9 years Railroad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဥ George Albert Spencer Fannie Pearl Pergorey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lee Moricle (Step Son) 6927 Gough Street Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Pk. 6/21/2007 Dorsey, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final FAILURE Physician ZDAXS disease or condition resulting in death) /Medical UNCOUNTE OBSTRUCTIVE PULLDUTRY DIESS Due to (or as a consequence of): VERE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner bunial-transi and Due to (or as a consequence of) 68760, attending physician Physician/Medical the use as t IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.O. cate has been signed by the page 2 should be detached 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1☐ Yes or Vital 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes Medical Certification: To 28d. Describe how injury occurred 27 Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? (Month, Day or Attending Division Natural 2 ☐ Accident 5 ☐ Pending investigation s after death.

I Director: Af 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide within 24 hours a To the Funeral I Hospital i A ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d, Date signed (Month, Day, Year) 29c. License number

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SPENCER,

State Registrar 31. Date filed (Month, Day, Year)

icea quiz, ma Name and address of person who completed cause of death (Item 23a) (Type, Print)

Upper Chesapeake Medical Center, Bel Ar Maryland
32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 2007 9:44 P June 17, Charles Matthew Smith /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 400 Gwynnwest Road Reisterstown If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 X M 2 □ F Months Davs Hours 62 March 15, 1945 Maryland Director 212-48-7527 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County or 28a-f show Ex miner must be notified at 1 ☐ Yes 2 X No Directo Maryland Baltimore Reisterstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a 21136 USA 400 Gwynnwest Road Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 o, 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 M Divorced **Black** 'natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) other than Elementary/Secondary (0-12) 02 Manufacturing 12 Machinist other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event one. Be 2 Marie Smith <u>Margaret</u> Melvin 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21136 400 Gwynnwest Road, Reisterstown, Maryland Mary Ann Beale/Fiancee 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 6/21/07 Gough Meth. Ch. Cem. Cockeysville, MD Bryan W. C 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley In
10 W. Padonia Road, Timonium, MD 21093 Clary 23a. Part1 nter the disease, or comilication shows, or heart failure. List only ne ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** 3 mon4/Medical Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed 4 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IE EEMALE: . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctonic pregnancy Month Dav Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 26. Place of Death (Check only one) Medical Certification: To Be 25. Was case referred to medical Other: 4 Nursing Home 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 28a. Date of Injury 28b. Time of 286. Describe how injury occurred 27. Mann 28c. Injury at Work? (Month, Day Year) Injury atural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

To the Hospital within 24 hours a To the Funeral I

State Registrar

5

31. Date filed (Month. Day, Year) JUN 2 2 2007

Yousuf Gaffar, M.D.

29b. Signature and time of ce

82. Registrar's Signature

30. Name and address of pe son who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Mghth, Day, Year)

9:15

Birthplace (State or Foreign Country)

10d. Inside City Limits

21237

21237

Approximate Interval Between Onset and Death

1 ☐ Yes 2 ☐ No

BALTIMORE

MARYLAND

U.S.A.

Month

Day

Year

Black, White, etc.

 $A^{M}$ 

Registrar DHMH 17 Rev 1/2001

State

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 16b, 19b per fh e868 6-22-07 vt. State of Maryland 7 Department of Fieath and Mental Hygiene amend items 12, 19a per inf 2869 7 1-07 vt. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Dav Year 2:45 AM Schook June 20 /Medical 2007 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Suburban Montgomery Bethesola Hospital 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) 1 M 2 F Months Days Hours Min. 81 147-16-4695 Director 07, 05, 1925 AUSTRIA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notifled at 1 ☐ Yes 2 ☐ No Director MD MONTGOMERY BETHESDA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7912 PARK OVERLOOK DRIVE 20817 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status າ "natural", or Items ledical Examiner ກ Black, White, etc. 1**X** Yes <del>2 No</del> If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: WHITE Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 hr Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natul any Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) AERONAUTIC Elementary/Secondary (0-12) College (1-4or 5+) 5+ NUCLEAR PHYSICIST **AERONOTIC** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be IGNAZ **SCHOCK** GOLDCHA THAU ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3911 BOSWORTH DRIVE S. W. - ROANOAKE, VA. 240 19a. Informant's Narce (Text Type, Print) SYLVIA SCHOENFELD/EXECUTRIX 3911 BOSWORTH DRIVE S. VA. 24014 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 M Removal from State 4 ☐ Donation 5 ☐ Other (Specify) **HEBRON** 06/22/2007 FLUSHING, NEW YORK 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiamy of athy ischemic Due to (or as a consequence of): Years /Medical **Examiner** artery Due to (or as a nunsequence of) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 687607 Physician/Medical the IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy I or Attending Physician: The law requires that the death after death.
Director: After this certificate has been signed by the atter in in by the funeral director, page 2 should be detached for it in by the funeral director, page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a To the Funeral D 1 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 165491 June 20, 2007 MY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 Schwartz Daniel 8600 Old Georgebun Rd, Bellesch, MD 20814 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

SCHOCK, ALPRED

			1 - For State Registrar		e of Ma	arylan	-	artment of H		7		Reg. No.	007	202	52
75	Physicia	an	1. Decedent's Name (First, Mic Lillian Wilhe		oltin	ıg				1	2. Date of D Month 06	Day	2007	3. Time of	
	/Medic Examin		4a. Facifity Name (If not institut					4b. City, Town, or	r Location	of Death	00		County of Death	9:00	_a ™
	3		National Luthe	ran Home				Rockvil1				Mon	tgomery	<i>J</i>	
	Funeral		5. Social Security Number 099-03-7104	6. Sex 1 ☐ M 2		e (In yrs. 92	last birthday) Yrs.	If Under 1 Year Months Days	If Unde Hours	Min.	B. Date of Bi (Month, D	ay, Year)	Co	nplace (State o untry)	or Foreign
	Director		Usual Residence of Decedent			92					)9-03-	1914	New	York_	
	anylan ehow	L	10a. State 10b. Cour				y, Town or Lo							10d. Inside Ci	
	the Mi	ecto	MD Mont  10e. Street and Number	gomery		Roo	ckvill	10f. Zip Code				10g Citiz	en of What Co		-
	3e or	i Dir	9701 Veirs Dr.					20850				USA		, -	
	eme 2	ner	11. Marital Status	12. Was	Decedent d Forces?	Ever in U.	S. 13.	Was Decedent of H	ispanic O	rigin? (Spec	ify Yes or N		4. Race - Amer Black, White		
36	s after	by Funeral Director	1 Never Married 2 M 3 Widowed 4 Divorc	arried 1 🔲	es 2 s, Give or Dates:	No	1	1□Yes 2XNo	Specify				Specifywhit		
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or teme 23a or 28a-f ehow that the Madical Examinat must be notified at	ted b	15. Deced	ent's Education			16a. Dece	dent's Usual Occup	ation				d of Business/l		
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121	fygien tygien her th	Cou	12 17. Father's Name (First, Middle	o (act)			Statis	Stician	19 Moth	ner's Name	Eirst Middle		rnment		
lanc	d be f	To Be	Henry John Sto							ene Wi	- "				
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Iteme 23a or 28a-f show appring to other traumatic svent, the Madical Examination at a profit of the contract of the contr	-	19a. Informant's Name/Relation	nship (Type, Print			19b. Mailir	ng Address (Street						lip Code)	
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68760,	ificate be executed by physician and street burial-transit	dicai Examiner	Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	e to (or as	A EST a conseq	uence of):		F-A	ILUR					
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Ω.	w requires that been signed b should be deta	ed by Pt	Part II. Other significant cond	tions contributing	to death t	out not res	ulting in the u	nderlying cause giv	en in Part	11,		tobacco us	se contribute to	the cause of cobably 4 🔲	
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	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director.	Medical	29a. Certifier Certif (Check only one)	al Examiner: On	o the best the basis o manner st	f examina	wledge, deat tion and/or in	h occurred at the tin vestigation, in my o	ne, date a pinion, de	and place, ar eath occurred	nd due to the d at the time	e cause(s) , date and	and manner as place, and due	stated. to the cause(s	s)
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	17		30. Name and address of pers		_		1 23a) (Type,		850		VA	TT) .	AWTHO!	my 110	)
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DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 10:45 AM M June 15, 2007 Robert Bruce Scott 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Shanti House Prince Georges Laure1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 10€ M 2 □ F 53 04/17/1954 156-48-4873 NJ Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 24 No Silver Spring Montgomery 10e. Street and Numbe 10g. Citizen of What Country? 10f. Zip Code 20904-United States 1232 Kathryn Rd. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married Yes 2 2 No 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Transportation College (1-4or 5+) Elementary/Secondary (0-12) Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John E. Scott Doris Stroud 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shellie J. Scott/Wife 1232 Kathryn Rd. Silver Spring, MD 20904-20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Jun Beltsville, Maryland 4 Donation 5 Dother (Specify) 2007 Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cirrhosis of Liver disease or condition resulting in death) years Due to (or as a consequence of) Alcoholism Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the cause of the ca Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 Tyes 2 TNo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an perform 2 No 1∐ Yes 26. Place of Death (Check only one)

**Physician** /Medical Examiner Examiner

**Physician** 

Examiner

**Funeral** 

Director

28a-f show

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Department of H Important: If ite any Injury or ot once.

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Directo MD

Funeral

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death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

3altimore, Maryland 21215-0036

/Medical

The law requires that the death certificate be executed and attending physician for use as the burial signed by peen ate has page 2 or Attending Physician: After this certific within 24 hours after death To the Funeral Director: þ

P

Certification:

Medical

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

Records, P.O. Box 68760

ivision or Vital

Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown 9 Hypertension, Diabetes Completed Be

25. Was case referred to medical examiner? Hospital: 1 ☐ Yes 20 No 1 Inpatient 27. Manner of Death 28h Time of 1/X Natural

2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 ☐ Could not be

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier m

determined

29c. License number D23181

29d. Date signed (Month, Day, Year) 06-19-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G. Bhojras MD 704 Gorman Ave T-1 Laurel MD 20707

State Registrar

10

31. Date filed (Month, Day, Year) JUN 2





07-04642 Warren Threat

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	Certificate	of Death	Reg. 1	ZUU No.	1 2020
Physicia	in/	Decedent's Name (First, Middle,Last)			Date of Death     Month Da		3. Time of Death
Medical Exami		WARREN		THREAT	June 18, 200	7	0731 hrs
		4a. Facility Name (if not institution, give street ar 2017 N. Monroe Street	d number)	4b. City, Town, or Location of Death Baltimore	1	4c. County of Death	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)		s. 8. Date of Birth(N	M/DD/YYYY) 9. Bir	thplace (State or
Director		UNKNOWN 1XM 2	1.3	Months Days Hours Min		Foreig	
any	1	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loc	cation	/		10d. Inside City Limits
* ·	_	MARIULAUA ALLA		BAITIM	ORE C	177/	1 Yes 2 No
Sa-f s	읈	10e. Street and Number		10f. Zip Code	01 10	Citizer of What Cour	ntry?
th the Maryland 23a or 28a-f she	Director	2017 MONROE	STREET	21217	7	USF	7
death with the Maryland or items 23a or 28a-f shemust be notified at once	Funeral	1 Never Married 2 Married Arm	ed Forces?	Nas Decedent of Hispanic Origin? ( S f Yes, specify Cuban, Mexican, Puerto		14. Race - Ameri White, etc.	can Indian, Black,
fler de		3 Widowed 4 X Divorced If Yes, Giv	es 2 No Year 1	Yes 2 No specify:		Specify: B1	ACK
ours a	d b	15. Decedent's Education (Specify only highest		lent's Usual Occupation (Give kind of	work done 16	b. Kind of Business/I	ndustry (UNKNOWN)
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5-0036 led within 72 Hygiene. other than	mo	12 FHGRADE 17. Father's Name (First, Middle, Last)		LABORER 18 Mothers Name	e (First, Middle, Maid	Ion Cumama)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C	FR NEST	THRE		the state of the s	en surname)	POONE
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MD d 2 sho lth and lth and n 27 is numati	1	JOVCE L. WILSON (E	X-WIFE 25	OI VIOLETAY			
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Baltimore, permit. Pages 1 a Department of He Important: If it		21. Signature of Funeral Service Licens	22	Alama and Addison of Francis of	ROWNJA	4	AL HOME
	-	23 a. Party/Enter the disease, or complications the	at caused the death. Do not ente	2140N FUL	TON AVE	BALTO,	MD- 2/217 Approximate Interval
Physician // Medical	1	failure. List only one cause on each line.			or reophatory arrest,	SHOOK, OF HOUSE	Between Onset and Death
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ords, F w requires s been sign should be	Completed	· ·			24a. Was an	24b. Were au	topsy findings available
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Examiner: On the b	isis of examination and/or investi	curred at the time, date and place, and gation, in my opinion, death occurred			
To Wiji	Me	29b. Signature and title of certifier	ner stated.	29c. License number	29	9d. Date signed (Mor	nth, Day, Year)
(6)		Course Ha	llan	O.C.M.E.	J	une 18, 2007	
	1	30. Name and address of person who completed Carol Allan, MD Assistant Medi	, , ,	n Street, Baltimore, MD 2120	11		
St	ate	31. Date filed (Month, Day, Year) 3	Resistrar's Signature	1 Street, Datumore, NID 2120	71		
Regist	rar	JUN 2 2 2007	Storm A	2348			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** OWH 140 Z00-/Medical Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day 9. Birthplace (State or Foreign **Funeral** If Under 1 Year Days 1 □ M 2 1 F Director ar ana Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at Yes 2□No Director MOLE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. If Item 27 is marked other than "natural" or hours any Injury or other treasment. Funeral 2. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 No Specify. ٥ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Wrenc 19a. Informant's Name/Relationship (Type. Print) (daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md. 2120 as 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 12007 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service/Licensee 22. Name and Address of Facility W. North Ave. Balto. Home Md. 23a. Part I ner the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ships, or heart fillure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a or not quence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine consequence of) sician and burial-transit Division or Vital Records, P.O. Box 68760, signed by the attending physician detached for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 mon Month Day Year 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No perform To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 1 10 1 Dapatient P 2 ER/Outpatient 3 DOA 27. Manner eath 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural (Month, Day 5 ☐ Pending investigation 1 Tes 2 No 2 ☐ Accident 6 Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifi-29c. License number (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

JUN 2 2

32 Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State	Cert	ificate of L	Death	- Wierkar	iygici ic	Reg. No.	200	7 2026
Physician ledical Examine	1	. Decedent's Name (First, Middle,Last)	OSHUA DWYA	NE TUR	NER		2. Date of Do Month June 19	Day	Year	3. Time of Death 1336 hrs
	ľ	a. Facility Name (if not institution, give street Howard County General Hospita			. City, Town, or L Columbia	ocation of Deat	h	4c. Co How	unty of Death ard	i
Funeral Director		5. Social Security Number 6. Sex 1 X M 2	7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24Hi Hours Mi		30/19	Foreig	thplace (State or gn puntry) MD
faryland 28a-f show any Latonce,		Usual Residence of Decedent 10a. State 10b. County MD CARROLL	1	Town or Location	STER					10d. Inside City Limits 1 Yes 2 No
the Maryland sa or 28a-f sh		10e. Street and Number 431 BARNES AVE.			10f. Zip Code 211	57		10g. Citizen US		ntry?
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.  ant. If item 27 is marked other than "natural", or items 23a or 28a-f she or other tranuatie event, the Medir Lexaminer must be notified at once		1 X Never Married 2 Married 1 1 3 Widowed 4 Divorced If Yes, or Date	ės'	If Yes	Decedent of Hisp s, specify Cuban, Yes 2 X No	Mexican, Puert specify:	o Rican, etc.)	Spe	White, etc.	ican Indian, Black, $HITE$
5-0036 led within 72 hours Hygiene. other than "natur the Medi - I Exam	1	15. Decedent's Education (Specify only high Elementary/Secondary (0-12) Co	est grade completed) ollege (1-4 or 5+)	during mos	s Usual Occupation of working life.	DO NOT use re			of Business/	
ID 21215-0036 Should be filed within 77 is marked other than Aris marked other than matter event, the Medical Tries of the Medical Communication of the Medical C	١,	17. Father's Name (First, Middle, Last)	LEY HOWARD		1	8.Mother's Nan	ne (First, Middle	e, Maiden Sur	name)	
y, MD 2121 and 2 should be filealth and Mental Rem 27 is marked traumatic event,	2		- MOTHER	431 B	Address (Street	AVE.,	WESTM	INSTE	R, MD	21157
Baltimore, ME permit. Pages I and 2 s Department of Health as Important: If item 27 Injury or other trauma		20a. Method of Disposition  1	moval from State	rematory or othe OW BRA	NCH CE	M. 6/	Date 23/07 ETCHE	WEST	· rmtns:	TER, MD HOME, P.A.
Physician /Medical	1	23a. Part I finte the disease, or complication failure. List only one cause on each line Immediate Cause (Final disease a. Hang		254	E. MA	IN ST.	, WES	rmins:	rer, i	MD 21157 Approximate Interval Between Onset and Death
xaminer		or condition resulting in death)  Due to  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause  c.	(or as a consequence of) (or as a consequence of) (or as a consequence of)	):						
Box 68760, each certificate be executed the attending physician and ad for use as the burial - transi	nysician/inedical	UNPENDED AME	NDED  If yes, outcome of pregn Live birth Pregnant at time of dea	2 Feta	al death 3 er (Specify)	Ectopic pregi	nancy		ate of deliver	ry Day Year
, P.O. Be ires that the designed by the standard for	<u>ب</u>	Part II. Other significant conditions contril	buting to death but not re	sulting in the un	derlying cause gi	iven in Part I.				o the cause of death?
ords law requi	nataldulo						pe	as an topsy rformed? s 2 No		utopsy findings available completion of cause of
Vital Recysician: The his certificate director, page		25. Was case referred to medical examiner?				of Death (Chec				
f Vital Physician: er this certi	إ ٰ	1 Yes 2 No	a. Date of Injury	ER/Outpatient 28b. Time of Inj		y at Work?	ing Home 5	Residence		er: 
Division of tall or Attending Phras after death.  al Director: After led in by the funeral	Certification:	1 Natural 5 Pending Pacification Investigation	OUND: lun 19, 2007 8e. Place of Injury - At ho	FOUND: 1215 hrs	1 Y	es 2 🗸 No	Subject h	anged self		tural Route Number, City
Divis  To the Hospital or A within 24 hours after To the Funeral Bire completely filled in b		4 Homicide determined	Specify) Jail/Penal				or Town 2555 Wate	i, State) rloo Road, J	lessup, MD	
D To the Hospital within 24 hours To the Funeral completely filler	edica	one) 2 Medical Examiner: On the	o the best of my knowledge basis of examination ar manner stated.	ge, death occurre	ed at the time, dat on, in my opinion, 29c. License	death occurred	nd due to the c d at the time, da	ate and place,	and due to t	he cause(s)  onth, Day, Year)
		30. Name and address of person who comple	ted cause of death (Item	23a)	O.C.N				20, 2007	, Day, 1601/
3	╛	Jack Titus MD. Deputy Chief	Medical Examiner  32 registrar's Signatu	111 Penr	Street, Balt	imore, MD 2	21201			
Sta Registra		31. Date filed (Month, Day, Year) JUN 2 2 2007	32 Registrar's Signatu	Goar		<u> </u>				

			1 - State Registrar	State of Marylan	•	artment of Health a rtificate of Death		Reg.	C UI		20267
	Physici	an	1. Decedent's Name (First, Middle, Last)  KETTH	THOMAS				Date of Death Month	Day 18	Yeer 200	3. Time of Death 7 9:50 PM
,	/Medio Examin		4a. Facility Name (If not institution, give si HARBOR HOSP	treet and number)		4b. City, Town, or Location of BALTIMO	of Death		4c. County		/
	Funeral Director		5. Social Security Number 6. Sex	M 2□F	Yrs.	If Under 1 Year If Under Months Days Hours	Min. 8.	Date of Birth (Month, Day, Yo	961	9. Birthpla	ce (State or Foreign
	ith the Maryland or 28a-f show	tor	10a. State 10b. County  Maryland N	10c. Cit	y, Town or Lo	Balting	ore			100	d. Inside City Limits
	ath with the 23s or 28 ust be not	Funeral Director	10e. Street and Number Broad	dwax		10f. Zip Code 212	13	10g.	Citizen of V	What Country	y?
020	72 hours after death with the Maryland "natural", or frame 23e or 28e-f show wical Examiner must be multified at	by	11. Marital Status  1 Prover Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of Hispanic Ori If Yes, specify Cuban Mexicar 1 ☐ Yes 2 ☐ Mo Specify:	n, Puerto Ric	y Yes or No- an, etc.)		e - Americar ck, White, et : Blac	
2.61213	c * 3	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occupation kind of work done during mos DO NOT use retired)		16	. 4.		stry
אומותי	s 1 and 2 should be filed within f Heelth and Mental Hygiene. Itam 27 Ia marked othar than othar traumatic avent, tha M	To Be C	17. Father's Name (First, Middle, Last) Albert Thomas			Ka	then	re Ba	wn		3,212
, <b>T</b>	t and 2 sh teelth and im 27 la m har traum			as-sister	129	ng Address (Street and Number No. Broady		Balti	More	Mar	yland
	permit. Pages 1 an Depurtment of Heel Important: If Itam 2 any Injury or other once.		20a. Method of Disposition  1	emoval from State	emetery, cre	natory or other place)	6/26	107 E	Batter	Mre	Mayland
0	Dep.		21. Signature of Funeral Service License	· Harter	/ 3	572 Frederic	ick?	ertus	attim	ore, 1	Maryland
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	eations that caused the deather cause on each line.  HYPOYLO  Due to (or as a consequence)	PES uence of):	PIRATORY :	cardiac or re			lr Ir	Approximate Interval Between Donset and Death
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	uence of):	IDOCIS					I DAY
,00,	ete be executed hysiclen and the burial-transit	icai Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	uence of):	AILURE					1 DAY
O. BOX 00	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 bours elected death.  Of the Funeral Diffector: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Sc. If yes, outcome of pregna 1 ☐Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Idéath 3[	Ectopic pregnancy			23d. Dat	te of delivery inth D	/ Day Year
L (CD)	quires that n signed b uld be deta	þ	Part II. Other significant conditions conf HIN	tributing to death but not resi	-						cause of death?
	sician: The law re certificate has bee lirector, page 2 sho	Completed	COAGULOPATHY IN DRUG USE HIST					24a. Was an autopsy performed	1?	death?	sy findings available pletion of cause of
N 150	siclan: certific rector,	Be	25. Was case referred to medical examiner?	neoital:		Other		check only one)			
5	ding Physician: The h. h. After this certificate his tuneral director, page	on: To	1 ☐ Yes 2 ☐ No  27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	1 3 DOA 4 110		5 Residence  I. Describe how			
DIVISIO	To the Hospital or Attending F within 24 hours effer death. To the Funeral Director: Affer completely filled in by the funer	er ification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, st	M 1 Yes 2		Location (Stree City or Town, S		er or Rural F	Route Number,
	To the Hospital or Attenwithin 24 hours efter deat To the Funeral Director: completely filled in by the	edical C	(Check only one)	icium. To the best of my kno er: On the basis of examina and manner stated.	wladge, deat tion and/or in	n occurred at the time, date an vestigation, in my opinion, dea	d place and th occurred	fdua to the eause at the time, date	and place,	anner as stat and due to th	ted he cause(s)
	Withii Comp	Ň	29b. Signature and live of certifier			29c. License number	4		•	d (Month, Da	•
	3		30. Name and address of person who cor		23a) (Type,					-	2007
	Sta	ite	31. Date filed (Month, Day, Year)	LO MD 30		HANOVER S	11. P	44 IMC	RE'	VW 2	177>

DHMH 17 Rev 1/2001

			State of Maryland / D	epartment of F Certificate of		ntal Hygiene () (	07 20268
		1. Decedent's Name (First, Middle, Last)			2	Date of Death Month Day	3. Time of Death
	Physician	Kenneth E	Willen				2007 11:11 pm
	/Medical Examiner	4a Facility Name (If not institution, give s	treet and number)		4b. City, Town, or Loca	tion of Death 4c. County	of Deeth
		Franklin Square H	ospital		Kosedale		nore
	Funeral Director	5. Social Security Number 6. Sex 15		Months Days	Hours Min.	Date of Birth (Month, Dey, Year)	9. Birthplace (State or Foreign Country)
	v	Usual Residenca of Decedent					•
	death with the Maryland me 23e or 28e-f show r must be notified at nerai Director	10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits 1 ☐ Yes 2 No
	tter death with the Ma r items 23a or 28a-fa ciner must be nortified Funeral Director	10e. Street and Number	10.10	not. Zip Code		10g. Citizen of W	/hat Country?
	23a 23a 23a 23a 23a 23a 23a 23a 23a 23a	2807 Munster	rRoad	216	234	US	A
	dear dear		Was Decedent Ever in U,S.     Armed Forces?	13. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Specian, Mexican, Puerto Ri	fy Yes or No- can, etc.) 14. Race Blace	a - American Indian, k, White, etc.
020	within 72 hours after one. than "naturel", or ite to Medical Examinal or mpleted by Fui	1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	1 XYes 2 □ No If Yes, Give Year or Dates:	1 ☐ Yes 2 🛣 No		Specify:	White
IEN, Kenneth Maryland 21215-0020	2 hou	15. Decedent's Educ	eation 16a I	Decedent's Usual Occup	pation	16b. Kind of Bu	siness/Industry
25 25	Find and a second secon	(Specify only highest grade Elemantary/Secondary (0-12)	Completed) (College (1-4or 5+)	Give kind of work done life. DO NOT use retire	during most of working id)	11/20/200	Electric
2 2	filed within 72 ho Hygiene. ther than "nature int, the Medical I Completed	12		iet up			
of Dr	tel Hyging of other event, I Be Cc	17. Father's Name (First, Middle, Last)	,	,		First, Middle, Maiden Sumam	Θ)
× ya	should be fill marked off marked off umarked Albert Wil	llen		Edna	Keyser		
Mar	d 2 should be filed with th end Mentel Hygiene. 7 Is marked other than traumatic event, the M To Be Comp	19a. Informant's Name/Relationship (Typ		V 120	t and Number or Rural	Route Number, City or Town,	
= 3	E 8 24 F		ig-niece 861	9 Silver Know Disposition (Name of	oll Drive	Date 20c. Location	land 21128 City or Town, State
W     Baltimore,	Peges 1 en of Henrich Henrich Henrich Henrich Henrich Homen	20a. Method of Disposition  1 ▶ Burial 2 □ Cremation 3 □ Re	cometen	r, crematory or other pla	ice)		
÷ i	P in the	4 Donation 5 Other (Specify)	Highvie	w Memorial	Gardens 1	-101 Hallston	Maryland
Saj	pemit. Depertr Importu eny inj	21. Signature / uneral Servica License		Evans Fur	neral Chaf	el and Crema	tion services
	20200	111/0/51	14	18800 Harfa	ord Road f	arkville Maryla	ind 21234
		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death. Do no e cause on each line.	ot enter the mode of dyi	ng, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Death
	Physician	Lucyalista Cours (Final	0				Grigor and Boarn
	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	Pheumonia				
	<u>.</u>		Due to (or as a co	onsequence of):			
M	axec ted in end iel-transit Examiner	<b>b</b>	Due to (or as a co				1
~	be axec ted siclan enc buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.	Due to (or as a co	onsequence or).			
,092	ate be asso ted hysician encithe buriel-transit	that initiated events	Due to (or as a co	onsequence of):			
39	ificat g phy es th	resulting in death) Last					i
ŏ	Attending Physicien: The law requires that the death certifics robest.  Archestl.  Arche	d					
ω.	daati e etta ed for	Part II. Other significant conditions conf	tributing to death but not resulting in	the underlying cause gi	iven in Part I.	23b. Did tobacco usa cor	ntributa to the cause of death?
O.	by the e	Congestive Heart	Enilure			1 ☐ Yes 2 ₺ No	3 ☐ Probably 4 ☐ Unknown
ď.	es tha igned be dail	Congestive treats	TUILVIC	Manager 1			Lan III
pro	v require been si should					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause
ပိ	law nas be					,	of death?
<u> </u>	ata h page					1 ☐ Yes 2 ☑ No	1 ☐ Yes 2 ☐ No
/ita	ystclen: The law lis certificata has t director, page 2 s	25. Was case referred to medical			26. Place of Death	Check only one)	
<b>1</b>	Physic this can all dire	1 ☐ Yes 2 1 No	ospital: 1 Inpatient 2 ER/Out	patient 3L DOA		e 5 ☐ Residence 6 ☐ Oth	
Ē	ther the uners	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28e. Date of Injury (Month, Dey Year) 28b. To	jury Wo		d. Describe how injury occurr	red
<u>S</u>	leath. tor: A the f	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	and Diversity Athens for		Yes 2 No	f. Location (Street and Numb	per or Rurel Route Number
Division of Vital Records, P.O. Box	tal or Attending Pris effer death.  al Director: Affer the did in by the funera Certification:	4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	20	City or Town, State)	igr of Train rights (valid),
_	To the Hospital or Attending Pr within 24 hours effer death. To the Funeral Director Affer completaly filled in by the funeral Medical Certification:	29a. Certifier (Check only one)	sician: To the best of my knowledge, her: On the basis of examination and and manner stated.	death occurred at the t Vor investigation, in my	ime, date and place, ar opinion, death occurre	d due to the cause(s) end ma d at the time, date and place,	anner es stated. and due to the cause(s)
	ithin the office of the omple	29b. Signature and title of Certifier		29c. Licen	se number	29d. Date signe	d (Month, Day, Year)
	⊢≯⊢ŏ	1 Heles	9 MD	Do	062573	6/18	107
	~ 1.i	30. Name and address of person who co	polated cause of death (Item 23a) (	Type Print)			
	15+1	Debra Hutjerds	MD 9000 Frank	lin Square	Drive Bal	hmore MD	21237
	State	31. Date filed (Month, Day, Year)	32. Registrar's Signature	harles			

DHMH 16 Rev 6/95

		1 - For State Registrar	State of Maryland		artment of H			iene	20269
Physic /Med Exami	ical	Decedent's Name (First, Middle, Last)     Rev Rev Ce      4a. Fecility Name (If not institution, give s	street and number)	55Li	4b. City, Town, or	Location of De	2. Date of Deat Month	Day Year 20 200 4c. County of Dea	th
Funeral Director		220-32-3002		st birthday) Yrs.	ANNAPOL I  If Under 1 Year  Months Days	If Under 24 H Hours M		ANNE ARU (Year) 9. Bir (2) 1937	NDEL thplace (State or Foreign ountry) MD
ne Maryland 8a-f show oillied at	ector	Usual Residence of Decedent  10a. State  MD  ANNE ARU		Town or Lo	LIS			0. 000 - 1000 - 100	10d. Inside City Limits 1 X Yes 2 □ No
If the strength of the many strength of the many strength of the many strength of the strength	sted by Funeral Director	10e. Street and Number  43 WINDWHISPER LAN  11. Marital Status  1 Nover Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates:	16a. Dece	10f. Zip Code 21403  Was Decedent of H If Yes, specify Cuba  1 Yes 2 No  dent's Usual Occup- is kind of work done of	Specify:	(Specify Yes or No- erto Rican, etc.)	0g. Citizen of What C U.S.A.  14. Race - Am Black, Whi Specify:  16b. Kind of Business	erican Indian, te, etc. WHITE
filed within Hygiene.	e Completed	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	College (1-4or 5+)	ATTOI	DO NOT use retired		Name (First, Middle, I	LAW Maiden Sumame)	
should be nd Mental marked c	To Be	HAROLD  19a. Informant's Name/Relationship (Ty)	pe, Print)		LOCK	ANN and Number or	Rural Route Number	PRE	SSMAN Zip Code)
e, INGL 1 and 2 sho Health and em 27 is m ther treum		DEBRA F. HOLZMAN	PRESENTATIVE	3701 ( ace of Dispo	OLD COURT	ROAD #		IMORE, MD 20c. Location - City o	
Dallimory permit. Pages: Department of t Importent: If Ite any injury or of once.		1 Denation 2 □ Cremation 3 □ R  '4 □ Donation 5 □ Other (Specify)	emoval from State HAR	ZION	TIFERETH	06/	21/2007	ROSEDALE,	MD
Dermit Depar Impor any in		21. Signature of Funeral Service License		89	900 REIST	ERSTOWN	OL LEVINSO ROAD - P	ON & BROS. IKESVILLE,	, INC. MD 21208
Physician /Medical		23a. Pen1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. le cause on each line.  Due to (or as a consequi	olmu	ter the mode of dyin	g, such as card	$\cap$		Approximate Interval Between Onset and Death
ificate be executed  g physician and as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence).  Due to (or as a consequence).		nns				yle
. BOX OX death certific e attending p	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetel 4 □ Pregnant at time of de 9 □ Unknown	death 3	□Ectopic pregnancy			23d. Date of de Month	elivery Day Year
ecords, r.J. law requires that the as been signed by th	by	Part II. Other significant conditions con	ntributing to death but not result	Iting in the u	underlying cause giv	en in Part I.		bacco use contribute es 2 □ No 3 □ F	
al Reco	Completed				/			med? prior to death? 2. No 1 □ Ye	utopsy findings available completion of cause of
dis y	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  1. Manner of Death  1. Matural 5 Pending 2 Accident investigation		ER/Outpatie 28b. Time o Injury	Wor	er: 4 🗌 Nursin		ence 6 Other (Sp. ow injury occurred	acify)
To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: Atter the completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, st	reet, factory, office		28f. Location (S City or Town	treet and Number or F n, State)	Rural Route Number,
ne Hospit 124 hour 1e Funere	edical (	29a. Certifier (Check only one) 12 Certifying Phys	sician: To the best of my know ner: On the basis of examinati and manner stated.	vledge, deat ion and/or in	th occurred at the time the ti	ne, date and pla pinion, death o	ace, and due to the c ccurred at the time, d	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
	Me	The state of the s	he Chesapeake		D	e number 21438	2	9d. Date signed (Mor	_
le		30. Name and addless of person shadoo Michael J. LaPe	enta, M.D., 44	5 Defe		way, An	napolis, N	MD 21401	
S Regis	tate trar	31. Date filed (Month, Day, Year)	32 Registrar's Signat	eru	aske				

DHMH 17 Rev 1/2001

		-	_ State	ite of Maryland		artment of F rtificate of I			giene Reg. No.	007	20270
	10 3		Registrar  1. Decedent's Name (First, Middle, Last)					2. Date of De		. 447	3. Time of Death
	Physicia /Medic	al .	ROBIN	SUE		WAF		JUNE	18	_2007	11:10 P M
	Examin	er	4a. Facility Name (If not institution, give street	and number)		4b. City, Town, or WESTMINS	r Location of Death	1	4c.	CARROL	
	Funeral		DOVE HOSPICE HOUSE  5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bir	th V Year)	9. Bi	rthplace (State or Foreign country)
	Director		101-40-7906	X <sup>F</sup> 58	Yrs.	Months Days	Hours Willi.	06/23/			NY
	and w	-	Usual Residence of Decedent  10a. State 10b. County	195 City	NTON LO	cation					10d. Inside City Limits
	Mary a-f sho	ţo	FL PALM BEACH		<del>TON</del> B						1 □ Yes 24 No
	ith the	Director	10e. Street and Number			10f. Zip Code	_		-	zen of What C	country?
	eath w		11893 HABANA AVENUE	as Decedent Ever in U.S	5. 13.	Was Decedent of H If Yes, specify Cubi		pecify Yes or No		U.S.A. 14. Race - Am	
36	filed within 72 hours after death with the Maryland Hygiene. kther than "natural", or Items 23a or 28a-f show snt, <u>the Medical Examiner must be notified at</u>	by Funeral	1 Never Married 2 💢 Married 1	as Decedent Ever in U.\$ med Forces? ∐Yes 2 <b>X</b> No Yes, Give ear or Dates:		If Yes, specify Cub 1 ☐ Yes 2 🎇 No	an, Mexican, Puert Specify:	o Rican, etc.)		Black, Wh Specify:	ite, etc. WHITE
21215-0036	2 hou natura ical E	ted	15. Decedent's Education (Specify only highest grade com	nleted) I	16a. Dece	dent's Usual Occup	eation during most of wor	rkina	16b. Ki	nd of Busines	s/Industry
212	ifiled within 72 ho Il Hygiene. other than "naturent, the Medical	Completed		ollege (1-4or 5+)		kind of work done DO NOT use retired T D A I	d)	9	EDI	UCATION	M.
22	filed w Hygie ther th	CO	17. Father's Name (First, Middle, Last)	5+	PRINC	IPAL	18. Mother's Nan	ne (First, Middle			<u>\</u>
lan	be d all	To Be	EDWARD		CA	RL	MURIEL				LERNER
Maryland	ac is a		19a. Informant's Name/Relationship (Type. Pr	HUSBAND		ng Address (Street					
	ss 1 and of Health item 27 other tr		STEPHEN WARD / SON- 20a. Method of Disposition	20b. P	lace of Dispo	3 HABANA psition (Name of	1	Date		CH, FL	
altimore,	% <del>-</del>		1 🕅 Burial 2 ☐ Cremation 3 🕅 Remove 4 ☐ Donation 5 ☐ Other (Specify)	al from State	emetery, cire _LWOOD	matory or other pla		22/2007	LONG	ISLANI	D. N.Y.
altii	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee		2	2. Name and Addre	ess of Facility SC	L LEVIN	SON	& BROS.	., INC.
<u> </u>	e a E e		Muchall est	igel_						SVILLE	, MD 21208
I.			23a. Part I. Enter the disease, or complicator shock, or heart failure. List only one at Immediate Cause (Final	is that caused the death use on each line.	n. Do not en	ter the mode of dyll	ng, such as cardia	c or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequ	ence of):						6/11/07-6/Al
	Examiner		Commentally list conditions								GIIIO, OPPI
	od sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):						
)	xecute and	Examiner	that initiated events c resulting in death) Last	Due to (or as a consequ	uence of):						
58760,	icate be executed physician and s the burial-transit	edical E		·							
_			IF FEMALE:								
Box	The law requires that the death certificate has been signed by the attending I bage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	yes, outcome pf pregna □Live birth 2□ Fetal □Pregnant at time of de	Ideath 3[	□Ectopic pregnand □ Other (specify) _	У			23d. Date of d Month	lelivery Day Year
o	the de	ysic		Unknown							
S, D	w requires that the de been signed by the should be detached	by PI	Part II. Other significant conditions contribu	ting to death but not resu	ulting in the u	ınderlying cause gi	ven in Part I.				to the cause of death?  Probably 4 Munknown
ord	requir een si nould l										
Records,	has b	Completed						per	opsy formed?/	pnor t death	
Vital	hyslcian: The Is his certificate has I director, page 2		25. Was case referred to medical				26. Place of De	1□ Yes ath (Check only		1 □ Y	es 2 No
<u>_</u>	Physician: r this certifica ral director, p	To Be	examiner? 1 Yes 2 No Hospi	<sup>tal:</sup> 1 □ Inpatient 2 □		III 3 DOA					SPA)CE HOUSE
o u	IIng PI		1 Natural 5 ☐ Pending	Ba. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo	ryat ⊮rk? ]Yes 2 ∐ No	28d. Describe	how inju	ry occurred	
Division or	Attending r death. ector: After by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	ie. Place of injury - At ho	me, farm, st			28f. Location	(Street ar	nd Number or	Rural Route Number,
<u>S</u>	safter safter ai Dire	Certification:	4 ☐ Homicide determined	building, etc. (Specif	y) 			Chy or re	own, State	<del></del>	
	To the Hospital or Attending Ph. within 24 hours after death.  To the Funeral Director: After thi completely filled in by the funeral.	Medical (	29a. Certifier (Check only one)  1 Certifying Physicia 2 Medical Examiner:	n: To the best of my kno On the basis of examina and manner stated.	wledge, dea tion and/or i	th occurred at the t nvestigation, in my	ime, date and plac opinion, death occ	e, and due to the curred at the time	e cause(s e, date an	s) and manner od place, and c	as stated. due to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	^3	1:	29c. Licen	se number		29d. Da	ite signed (Mo	onth, Day, Year)
			· Kolata ke	se my ph	V	100	06459	)	6	11416	
	12		30. Name and address of person who completed to the complete state of the complete state	eted cause of death (Item	n 23a) (Type	Print)	MD Z	1157			
- 17	Str	ite	31. Date filed (Mahy), Pay Year?	32 Registrar's Signa	ature	11/1/14	1,111				
	Regist	ar			6						

07-04597 Warren W. Aikey

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physicia ical Examin		Decedent's Name (First, Middle,Last)							Reg. No.			
j								Date of De Month une 16,		Year	3. Time of D	
Funeral		Warren W. Aikey  4a. Facility Name (if not institution, give street and number)		4b. City, T	own or l	ocation of		une 16,		County of Deat	1052 hi	'S
Funeral		1404 Shade Tree Road Apt G		Essex		JCallOIT OF	Dealli			altimore Co		
Director			In yrs. last birthday)	If Unde Months	er 1 Year s Days	If Under Hours	24Hrs. 8 Min.		irth( <b>MM</b> /I	DD/YYYY) 9. Bir Forei	gn	or P A
ž.		Usual Residence of Decedent  10a, State 10b, County 10	- Ott. 7				L					
dow any			c. City, Town or Loc								10d. Inside (	
Maryland 28a-f show d at once.	흸	MD Baltimore  10e. Street and Number	Baltim	ore 10f. Zip	Code			- 1	10m Citi-	en of What Cou		2 K IV
vith the Maryland s 23a or 28a-f show	Director	1404 Apt G Shade Tree	Road		221					S A	nuy?	
BAITIMORE, MID 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 12. Was Decedent Ev	er in U.S. 13. V	Vas Deceder	nt of Hispa	anic Origin	n? ( Specif	fy Yes or N		14. Race - Amer	ican Indian. B	ack.
death or item	Funeral	1 Never Married 2 X Married Armed Forces? 1 X Yes 2	No	f Yes, specify	y Cuban, I	Mexican, F	Puerto Ric	an, etc.)		White, etc.		
ral", (iner.	b P	3 Widowed 4 Divorced If Yes, Give Year 6 2	<b>-</b> 67 1	Yes 2			A			Specify:	White	
hour "natu	ള	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12)  College (1-4 or 5+)	during	lent's Usual ( most of work					16b. K	ind of Business/	Industry	
than than edical	ompleted	1 2		Manag	emer	) t				Retai	1	
ed with the Market Mark	ခ <del>ြဲ</del>	17. Father's Name (First, Middle, Last)		3			Name (Fir	st, Middle	Maiden S			
ental Fill be fill be	<u>ا</u> ھ	Warren Foster Aikey					h Bu					
should and Min is may artice	٩	19a. Informant's Name/Relationship (Type, Print) Linda Thomas Aikey Wif	19b Mail	ing Address	(Street t	nd Nimbe	er or hure	Poute Nu	niber, Oit	y or Town, State	, Zip Code)	2.1.
and 2 and 2 ealth 2 tem 2	ŀ	Linda Thomas Aikey Wif  20a. Method of Disposition	20b. Place of Disp					ree	_	d Balt		212
ges 1: tof H : If it	-1	1 Burial 2 X Cremation 3 Removal from State	crematory or	other place)						ŕ		
it Pa irtmen irtant y or c	1	4 Donation 5 Other Specify: 21. Signature of Funeral Service/Licensee	Smiths	burg	Crem	1.	6/18	/200	7 St	nithsb	urg, N	1 D
Depa Impo		$\sim 0 / / / / / \sim$								sford		
hysician	1	23a. Part. Enter the disease, or complications that caused the	1176 110 death. Do not ente	J D 正 L A r the mode of	f dying, su	ch as card	cn S diac or res	piratory a	rest, show	erick,	MD 21 Approximat	
/Medical xaminer	ı	Immediate Cause (Final disease a. Chronic Obstructiv	e Pulmonary D	Disease							Between C Dea	
-xammer	-1	or condition resulting in death)  Due to (or as a consequ										
	ا پر	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequ										
	إ	Chicago or injury that initiated C.										
led nsit	Examine	events resulting in death) Last Due to (or as a consequence of the consequence)	ence of):									
		d. UNPENDED AMENDED	<del></del>				_					
ate be	Medical	IF FEMALE: 23c. If yes, outcome of	of pregnancy						224	Date of deliver		
e death certific the attending p ed for use as th		23b. Was decedent pregnant in the past 12 months?	2 🔲 F	etal death	3	Ectopic p	regnancy					Year
leath certific e attending I for use as th	Sician	1 Yes 2 No 9 Unknown g Unknown	e of death 5	Other (Speci	ify)				1			
t the d by the ached		Part II. Other significant conditions contributing to death but	it not resulting in the	underlying o	cause give	en in Part	I.	23e, Did	obacco u	se contribute to	the cause of d	eath?
signed by		Atherosclerotic Cardiovascular Disease			J					No 3 ✔ Prot		
been should	Completed	Chronic Alcoholism with Fatty Liver				_	_	24a. Was			topsy findings	
he law ite has	틹						-		ormed?	death?	ompletion of o	_
certificate ector, page		25. Was case referred to medical		26	6.Place of	Death (Cr	heck only		2 No	1 🗸 Ye	S 2	No
Physician: The law requirements continued in the control of the co	۱٥	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatie		10+	hor:	lursing Ho		Residen	ce 6 🗸 Other	: Scene	
fing Ph		27. Manner of Death 28a. Date of Injury	28b. Time of	f Injury 28	Bc. Injury a	at Work?	28d	. Describe	how injur	y occurred		
death.	] <u>§</u>	1 V Natural 5 Pending 2 Accident Investigation			1 Yes	2 N	•					
To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral Confiferation:	<u> </u>	3 Suicide 6 Could not be 28e. Place of Injury	- At home, farm, str	eet, factory,	office build	ding, etc.	28f.	Location (		d Number or Ru	ral Route Num	ber, Cit
hours neral y fille		4 Homicide determined (Specify)			-		1					
in 24 lin 24 lhe Fu	3	Certifying Physician: To the best of my knone)  2 Medical Examiner: On the basis of examina	owledge, death occ	urred at the ti	ime, date	and place	, and due	to the cau	se(s) and	manner as state	ed.	
To the Ho within 24  To the Fit completel		and manner stated.			License n		, cu at the	une, uate				
941	1	/ // //			O.C.M.				1.	ate signed (Mor	ип, µау, Year)	
OCME	-	80. Name and adoress of person who completed cause of death	(Item 23a)		3.3.111.	_· 		<del></del>	June	11, 2001		
UUNE	1	Mary G. Sipple MD. Deputy Chief Medical	,	11 Penn S	Street, B	altimore	e, MD 2	1201				
		at the state of th	A	- 0								

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2007 Physician 19, **JAMES** ALBRIGHT JUNE 0255 М /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS--Memorial Campus ALLEGANY CUMBERLAND 5. Social Security Number 8. Date of Birth (Month, Day, Year) Mar 10, 1929 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ★M 2 F 235-56-3651 78 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits show iral", or Items 23a or 28a-f show Examiner must be notified at Morgan Paw Paw 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with P.O. Box 145 25434 USA Completed by Funeral 12. Was Decedent Ever in U.S. Arged Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: **Korear** 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or Itel 1 Never Married 2 Married 1 ☐ Yes 2 ☐ 📉 Baltimore, Maryland 21215-0036 Specify. Korean Specify: 3 Widowed 4 Divorced white d Hygiene. d other than "natural event, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) laborer factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown Lottie Albright ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 N. Liberty St. Apt. 505 Cumberland MD 21502 19a. Informant's Name/Relationship (Type. Print) Marie Cowan sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If ite any Injury or of Camp Hill Cemetery 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/21/2007 Paw Paw WV 4 ☐ Donation \_ 5 ☐ Other (Specify) 21. Signature of Funeral Se 22. Name Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Enter the disease, or complications that cause, or heart failure. List only one cause on each Approximate Interval Between Onset and Death d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Imm liate Cause (Final Physician KESPIRATORY 1 DAY resulting in death) /Medical Due to (or as a consequence of): Examiner SPIRATION Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 1 DAY Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐Ectopic pregnancy Month Day Year 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached it 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has performe 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient ို 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 | Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Division or Vital Records, P.O. Box 68760, or Attending Physician:

within 24 hours after death.

To the Funeral Director: / the Hospital

(Check only one) 29b. Signature and title of certifier

29c. License number

1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

> JUNE |9 2007

30. Name and address of person who completed cause of death (Item 234) (Type, Print)

BERRERA 500 MEMORIAL AVE, CUMBERLAND MD KOBUSTIANO

State Registrar

5

4 Homicide

29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend line 26 per phy State of Maryland / Department of Health and Mental Hygiene? aaco hlth dept 06/08/07 dlw Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Shirley Ruth Allen June 6, 2007 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7320 Finns Lane Prince Georges Lanham Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Months 1 ☐ M 2 🛱 F Director 578-28-7083 81 05/17/1926 New Jersey Usual Residence of Decedent Show 10c. City, Town or Location 10b. County 10d. Inside City Limits at notified Directo MDor 28a-f Prince Georges Lanham

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █No If Yes, Give Year or Dates:

College (1-4or 5+)

10f. Zip Code

1 ☐ Yes 2 ☒ No

Secretary

20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematory

20706

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

22. Name and Address of Facility

ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify

18. Mother's Name (First, Middle, Maiden Surname)

Dolly Lee Leonard

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6/07/2007

8288 Elvaton Road, Millersville, Md 21108

16000 Annapolis Road Bowie, MD

s 1 and 2 should be filed within 72 now...
3/ Health and Mental Hygiene.
4/ Health and Mental Hygiene.
filtem 27 is marked other than "natural", or items 23a or filtem 27 is marked other than "hadical Examiner must be? 8 Baltimore, Maryland 21215-0036 permit. Pages 1 a
Department of Hei
Important: If item
any Injury or othe

10e. Street and Number

Funeral

Completed

Be

7320 Finns Lane

15. Decedent's Education (Specify only highest grade completed)

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

1 ☐ Never Married 2 X Married

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

John William Hughes

19a. Informant's Name/Relationship (Type. Print)

Stacy Berg /Daughter

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licenses

**Physician** /Medical Examiner

Box 68760

Division or Vital Records, P.O.

Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, france of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and I-transit curtificate be executed Due to (or as a consequence of): tending physician a for us as the burial-Physician/Medical as the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 HNo 4□Pregnant at time of death signed by the 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetic Renel Disease Completed peen Hypertension has page certificate 25. Was case referred to medical examiner? Be Hospital: 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After 5 Pending investigation within 24 hours after death.

To the Funeral Director; All completely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Hospital 1 decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: Ornshe basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of dertifier

23a. Part1. Enter the disease, or semplications that caused the shock, or heart failure. List only one cause on each line Severe Metebolic Acidosis Acute Renel Failure Cancer of the Colon 23d. Date of delivery 3 □Ectopic pregnancy Month Day 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No was a... autopsy performed? Ves & No 1∐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Inpatient 2 ☐ DOA 5 Aesidence 6 □Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

21883

29c. License number

YADLA.M.D. 9470 ANNA POLIS RASCULE#315 LANHAM, N. D. 20706

3. Time of Death

1 Yes 2 No

10g. Citizen of What Country?

16b. Kind of Business/Industry Prince Georges

County Schools

20c. Location - City or Town, State

Robert E. Evans Funeral Home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Dav. Year)

Alexandria, Virginia

14. Race - American Indian, Black, White, etc.

White

USA

3:25

Αм

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

JUN 0 8 2007

30. Name and address person who completed cause of death (Item 23a) (Type, Print)

Begistrar's Signature

			For State Registrar	State of Maryland	•	tificate of		u Memai ny	Reg. No.	20274
€.			1. Decedent's Name (First, Middle, Las.	)				2. Date of Do	eath Day Year	3. Time of Death
	Physici /Medic	_	EARL FRANKLIN A	MBROSE				JUNE	5, 2007	6:20 P <sup>M</sup>
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of D	eath	4c. County of Dea	th
		я.	FREDERICK MEMOR  5. Social Security Number 6. Se		hirthday	FREDER		Hrs. 8. Date of Bi	FREDER	ICK thplace (State or Foreign
	Funeral Director		205-22-2748	X M 2□F 77	Yrs.	Months Days		lin. (Month, D	ay, Year) Co	ountry)
	D		Usual Residence of Decedent					Mugust	22, 1949 1	Maryland
	arylar show dat	_	10a. State 10b. County	10c. City, T	own or Loc	cation				10d. Inside City Limits 1 ☐ Yes 2 XNo
	the M	Director	Maryland Frederi  10e. Street and Number	ck Roc	ky Ri	dge			10g. Citizen of What Co	
	with t	Ö		D 1			7.0			·
	mus	Funeral	9843 Rocky Ridge 11. Marital Status	12. Was Decedent Ever in U.S.	13. V	217 Vas Decedent of F		? (Specify Yes or Nuerto Rican, etc.)	United Sta	erican Indian,
9	after or ite	Ē	1 ☐ Never Married 2X Married	Armed Forces? 1  ☐ Yes 2	1	Yes, specity Cub		uerto Rican, etc.)		
215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:					Specify:	White
5-	"natu	Completed	15. Decedent's Edi (Specify only highest grad		(Give	lent's Usual Occup kind of work done DO NOT use retire	during most of	working	16b. Kind of Business	/Industry
212	withir iene. than the Me	ᇍ	Elementary/Secondary (0-12)	College (1-4or 5+)		enance R	•		Frederick	County
	illed Hygi other ent, t	Be C	17. Father's Name (First, Middle, Last)		чалис	enance k		Name (First, Middle	e, Maiden Surname)	Councy
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Heath and Mental Hygiene with them 23 are 18a-f show ttem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To B	Clarence Ambro	se			Grace	Brown_		
lar	2 should I and Men is marker aumatic		19a. Informant's Name/Relationship (7		19b. Mailin	g Address (Street	and Number o	r Rural Route Numl	per, City or Town, State,	Zip Code)
	1 and Health em 27 ther tr		Dorothy F. Ambro			Rocky Ri	dge Roa		Ridge, MD	21778
Baltimore,	Pages 1 nent of H int: If ite iny or ot	-	20a. Method of Disposition  1XXBurial 2 □ Cremation 3 □	Removal from State cem	e of Dispos etery, cren	sition (Name of natory or other pla	i	Date	20c. Location - City or	Town, State
Itim			4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Septice License		[abor	Cemeter	y 6/9	/07	Rocky Rid	lge, Maryland
Ba	permit. Departr Importa any inji		31. Signature of Purieral Service Licens		10	/ Foot M	oin Str	tauffer I	Funeral Home	es, P.A.
	ALC: U	/	28 a. P.m.1. Ent. / the is see, or component ock, or leart failure. List only of	lications hat cause the death. I	Do not ente	er the mode of dyi	ng, such as car	diac or respiratory	arrest,	and 21788 Approximate Interval Between
	Physician	1	Im rediate Cause (Final d'ease or condition	Acc	rte	myor	ordi	al In	fortisza	Onset and Death
74	/Medical		resulting in death)	Due to (or as a consequen	ce of):					
	Examiner		Sequentially list conditions,	b	5ty	<i>!</i> :				
	ted sit	nine	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequen	ee oiy:					
	execut and al-trar	Examiner	that initiated events resulting in death) Last	c Due to (or as a consequen	ce of):					
68760,	tificate be executed g physician and as the burial-transit	calE		d						
	tificat ig phy as the	ledical								
Вох	death cert e attendin d for use a	Physician/IV	23b. was decedent pregnant	23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal de		Ectopic pregnanc	y		23d. Date of de	•
.O. E	0 0	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of deat 9☐Unknown	h 5□	Other (specify) _			Month	Day Year
0	requires that the de een signed by the a hould be detached i		Part II. Other significant conditions of	ontributing to death but not resulting	a in the un	nderlying cause giv	ven in Part I.	23e, Did	tobacco use contribute to	the cause of death?
Records,	6 6	d by	<b>3</b>			,			Yes 2 No 3 P	
20	w requir been si should	Completed							an 24b Were a	utonsy findings available
Re	The law rate has be page 2 sh	g E						— auto perf	ormed?// death?	utopsy findings available completion of cause of
Vital		Be C	25. Was case referred to medical				26. Place of	1  Yes  Death (Check only		s 2□No
or V	Physiclan: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER	/Outpatien	t 3 OOA Oth	ner: 4 🗆 Nursir	ng Home 5 ☐ Res	idence 6 □Other (Spe	ecify)
	ding Phys h. After this of funeral dir		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	b. Time of Injury	28c. Inju Wo		28d. Describe	how injury occurred	
sio	r Attendi er death. irector A n by the fu	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	29a Diggs of injury. At home	form atre		Yes 2 No	OOF Location	(Chanada and Allanda and B	D to Market
Division	a er d a er d l Direc d in by	Certification:	4 Homicide determined	28e. Place of injury - At home building, etc. (Specify)	, iaiii, Sife	set, factory, office		City or To	(Street and Number or Ri own, State)	urar noute ivumber,
_	To the Hospital or Attending within 24 hours are death. To the Funeral Director: After completely filled in by the fune			/sician: To the best of my knowle						
	To the Hospita within 24 hours To the Funeral completely filled	Medical		iner: On the basis of examination and manner stated.						
	Nithir To th	ž	29b. Signature and title of certifier	^		29c. Licens	se number	,	29d. Date signed (Mont	th, Day, Year)

State Registrar 31. Date filed (Month Day Year) 1 2007

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2007 June 5, Diane ARKIN 7:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 121 Selby Street Gaithersburg Montgomery 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min. 1946 1 M 2 F 219-44-0357 June 6, Director 60 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he markshow any injury or other traumatic event, the Medical Examiner must he markshow and injury or other traumatic event, the Medical Examiner 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be 121 Selby Street 20878 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: white þ If Yes, Give \_ Year or Dates: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School Nurse Technician Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Abraham Bliden Frieda Yellin 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Richard Arkin, Husband Selby Street, Gaithersburg, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Garden of Remembrance 06/10/07 Clarksburg, MD 21. Signature of Fun and Cervi > Licensee Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Brain Cancer resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached it ☐Yes 2XNo 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 Yes 2 <del>∏</del> No 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tyes 2☐ No <sup>2</sup> 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 X Natural 5 Pending investigation To the Hospital or Attendia within 24 hours after death.
To the Funeral Director: Ar completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 0064615 June 6, 2007 (W) 30. Jame and address of person who completed cause of death (Item 23a) (Type, Print)
Genevieve Wroblewski, M.D., 1355 Piccard Drive, Rockville, MD 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar JUN 08 2007

		-	For State Registrar	tate of Maryla		artment of H rtificate of I		lental Hyç	giene Reg. No.20	07	20276	
	Physicia		Decedent's Name (First, Middle, Last)					Date of Dea     Month	ath Day	Year	3. Time of Death	
	/Medic	al .	Roy Aaron					June 2	2007 4c. County		9:30 A M	
1	Examin									imore		
	Euporol		Joseph Richey House  5. Social Security Number 6. Sex	7. Age (In yr	s. last birthday)	Baltimor If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h		ace (State or Foreign ry)	
	Funeral Director		331-24-2339	2□F 77	Yrs.	Months Days	Hours Min.	Nov 17		Illin		
	pu »		Usual Residence of Decedent  10a. State 10b. County	100.0	City, Town or Lo	cation				10	d. Inside City Limits	
	faryla shov ed at	ō									1 □Yes 2 No	
	the N 28a-i notifi	Director	Virginia Fairfax  10e. Street and Number	Fa	irfax	10f. Zip Code			10g. Citizen of	What Countr	ry?	
	h with		4316 San Juan Dr.			22030			USA			
	ems 2	Funeral		Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	. 14. Ra	ce - America		
36	s after	by Ft	1 Never Married 2 Married	1 XYes 2 No 19	51-	1⊡Yes 2√∑No	Specify:		Specii	fy: TTL-1-		
Ö	hour: Itural'	ed b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educat		16a. Dece	dent's Usual Occup	ation		16b. Kind of B	Whit Business/Indu		
21215-0036	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of work d)	ing				
212	ed with	Com		5 <del>+</del>	Sales				Automo	_		
pu	be file	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam			•		
<u>\Z</u>	d Mer narke	۵	Edward Aaron  19a. Informant's Name/Relationship (Type.	Print)	19b Maili	ng Address (Street	Frieda M				Code)	
altimore, Maryland	nd 2 si Ith an 27 Is r traur		Linda Antayhua - Ni		I	San Juan			-	,,,	,	
ē,	s 1 ar	8	20a. Method of Disposition	200	p. Place of Dispo cemetery, cre	osition (Name of matory or other place	ce)	Date	20c. Location	- City or Tov	vn, State	
E	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	loval from State	irfax C	rematory	June	6, 2007				
3alti	epartn nporta ny inju		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Everly Funeral Home  10565 Main St. Fairfax, VA 22030									
8	20 E 8 9		Hary Majuel		Do not no						Approximate	
		9	23a. Part1. Ent of the disease, or complica shock, or leart failule. List only one	cause on each line.	-		ig, such as cardiac	or respiratory a	rrest,		Interval Between Onset and Death	
	Physician / /Medical		Immediate vau e (Final disease or condition resulting in dea h)	Due to (or as a cons		ancel					1 year	
	Examiner			Due to (or as a cons	requerioe oi).							
	n #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease o. Injury that initiated events c	Due to (or as a cons	equence of):							
	ecuted and transi	Examine	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):									
60,	ficate be executed physician and s the burial-transit		rossiang in doubly basis	Due to (or as a cons	equence or,							
68760,	ficate phys s the	edical	d									
Box	± 5, 6	N/M	IF FEMALE: 23c. Was decedent pregnant	. If yes, outcome pf pre-		⊒Ectopic pregnanc	,			ate of deliver		
B	deatl	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of		Other (specify)	, 		M	lonth I	Day Year	
P.O.	at the d by th etach	Phy	9 ☐ Unknown  Part II. Other significant conditions contri		resulting in the I	inderlying cause giv	ven in Part I	23e. Did t	ohacco use cor	atribute to the	e cause of death?	
	w requires that the death cer been signed by the attendin should be detached for use	d by	Par II. Ories significant conditions contin	buting to death but not	resulting in the c	machy mg oddoo gm	on mir aich	1 🗆		3 ☐ Proba	./	
202	w requ	Completed				-		24a. Was	an 24b	. Were autor	osy findings available	
Re	e la has je 2	dmo						auto		prior to con death?	npletion of cause of 2 No	
ital	ilcian; Th certificate rector, pag	Be Co	25. Was case referred to medical				26. Place of Dea			TI TES		
or Vital Records,	dis y	To B	examiner? 1 Yes 2 No	spital: 1	ER/Outpatie	nt 3□ DOA Oth	ner: 4 ☐ Nursing H	ome 5 ☐ Resi	dence 6 🕩	ther (Specify	, HOSPICE	
u o			27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	Wo		28d. Describe	how injury occu	ırred	·	
Sio	Attending r death. ector: After by the fune	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of injury - A	t home farm st		Yes 2 ☐ No	28f Location (	Street and Num	nher or Rural	I Route Number,	
Division	lor Ail after c Direc	Certification:	4 ☐ Homicide determined	building, etc. (Sp	ecify)	reet, factory, office		City or To	wn, State)	ibel of Hillar	riodic riambol,	
_	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:		(Check only 2 Medical Examine	ilan: To the best of my r: On the basis of exam								
	To the P within 24 To the F complete	Medical	one)  29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Date sign	ed (Month, I	Day, Year)	
	H S H Ö		> Sten un			D	24170		June	2 2,	2007	
- 6	6		30. Name and address of person who com	pleted cause of death (	Item 23a) (Type	Print)	F 1	C 3 2	7 11.		17	
			E. Tso MD	pleted cause of death (	spice o	338 N	· Kutav	U ST F	Saltin	novel	1021201	
	Sta Regist		31. Date filed (Month, Day, Year)	SZ negrstrar's SI	J. A.	religi						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2<sup>Day</sup> **Physician** 2007 June Thomas Edward Bohmer 11:21p M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 799 Scarborough Court Arnold Anne Arundel 8. Date of Birth (Month, Day, Year)
Dec. 16, 1929 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Months Hours Min. 1**™**M 2□ F 77 NY Director 101-24-0663 Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits an "natural", or items 23a or 28a-f show Medical Examiner must be notified at Anne Arundel Arnold 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 799 Scarborough Court 21012 USA death v Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: þ Korea 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: if item 27 is marked other than "na any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Westinghouse 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Edward Bohmer Margaret Mitchell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 799 Scarborough Court, Arnold, MD 21012 Helen Bohmer/Wife **Baltimore**, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State June 6, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 2007 4 □ Donation 5 □ Other (Specify) Crownsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** month disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner executed burial-tra Due to (or as a consequence of): Box 68760, physician certificate be Physician/Medical the 88 attending IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No õ Month Day Year 5 Other (specify) 4☐Pregnant at time of death P.O. the 9□Unknown 9 Unknown b signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 certificate 1∐ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D39505

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31. Date filed (Month, Day, Year)

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JUN 0: 7 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

an 305 Hospit 32 egistrar's Signature

Registrar

al Dr. Glen Sumie MD.21061

			1 - For State Registrar	State of Maryland /	Department of Health  Certificate of Deat		Hygiene Reg. No.	07 20270			
	Physicia		1. Decedent's Name (First, Middle, Last) HAZEI MAE	HANDY BE	ckett	2. Date of Month	n Day	3. Time of Death 9:30 A·M			
	/Medic Examin		4a. Facility Name (If not institution, give si 426 Shirley Manor	treet and number)	46. City, Town, or Location REISTERSTO	on of Death	4c. County	•			
	Funeral Director		5. Social Security Number 6. Sex	M 2DXF 7. Age (In yrs. last bi		der 24 Hrs R Date		9. Birthplace (State or Foreign Country)			
	Maryland f show	tor	Usual Residence of Decedent  10a. State  10b. County  Some	RSET Ch	vn or Location  ance			10d. Inside City Limits 1 ☐ Yes 2 🔼 No			
	h with the 23e or 28e st be notil	Funeral Director	10e. Street and Number 23494 BECKE	_	10f. Zip Code 218	21	10g. Citizen of V	What Country? - S. A			
036	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other then "neturel", or Items 23e or 28e-f show or other treumetic event, the Medical Fran	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hispanic If Yes, specify Cuban, Mex 1 ☐ Yes 2 🗷 No Spec		or No- blac Specify	e - American Indian, ck, White, etc.			
Maryland 21215-0036	within 72 ho lene. r then "netu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		a. Decedent's Usual Occupation (Give kind of work done during n life. DO NOT use retired)	most of working		usiness/Industry mをみたと			
land 2	ould be filed Mental Hygi arked other etic event, I	To Be Co	17. Father's Name (First, Middle, Last)  Costen Hand	46	18. Mc	other's Name (First, M	liddle, Maiden Suman Zounds	ne)			
lary	2 should I and Ment Is marke		19a. Informant's Name/Relationship (Typ		b. Mailing Address (Street and Nu	_	, ,				
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Baltimore,	tmer tent tent		1 ☑ Rurial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	ST. Po	ery, crematory or other place)  Cometer 9  22. Name and Address of Fa	06-09-200 acility Anthony	Prince	SS Anno MD MERAL Home			
<u>~</u>	Depar Depar Impor any ir	111	Ahlling C. [	Ward Dr.	30639 Hampder	V AVE Prince	ss Anne, 1	ud 21853			
	Physician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Nonsmall Ce	Ulling Casci		ory arrest,	Approximate Interval Between Onset and Death			
	Examiner		Sequentially list conditions.	Due to (or as a consequence				/			
	ocuted nd transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence							
8760,	cate be executed physician and the burial-transit	dicai	resulting in death) Last	Due to (or as a consequence	o ot):						
.O. Box 6	death certifi e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	ac. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	h 3 □Ectopic pregnancy 5 □ Other (specify)			te of delivery nth Day Year			
<u>a</u>	n requires that the been signed by th should be detache	þ	Part II. Other significant conditions con	tributing to death but not resulting	in the underlying cause given in Pa	art I. 23e.	Did tobacco use cont	id tobacco use contribute to the cause of death?			
Vital Records,	as b	Completed					autopsy performed?	Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No			
<u> </u>	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatient 2 ☐ ER/O	Othor	lace of Death (Check of Nursing Home 5		er (Specify) Daughter Hon			
J Of	ding Phys n. After this funeral di	on: To	27. Manner of Death 1 Death 1 Death 1 Death 1 Death 1 Death 1 Death	28a. Date of Injury 28b.	Time of lnjury at Work?		cribe how injury occur				
Division	Attending r death. sctor: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, f	M 1 ☐ Yes 2		tion (Street and Numb	per or Rural Route Number,			
<u>≥</u>	Diffe	Certi	4   Homicios	building, etc. (Specify)			or Town, State)				
	To the Hospitel within 24 hours a To the Funeral completely filled	edical	29a. Certifier (Check only one) 1 redical Examin	ician: To the best of my knowledge. On the basis of examination a and manner stated.	ge, death occurred at the time, date nd/or investigation, in my opinion,	e and place, and due to death occurred at the	o the cause(s) and ma time, date and place,	anner as stated. and due to the cause(s)			
	To the within 2 To the complet	Me	29b. Signature and the of omitties	de	D W W 53	5.065	29d. Date signe	d (Month, Day, Year)			
5	EB		30. Name and address of person who con	mpleted cause of death (Item 23a)	(Type, Print)	Ad 27	5. breene	Ut Baltism			
	Sta		31. Date filed (Month, Day, Year) JUN 1 2 2	32. Registrar's Signature	A	,,		,			
DH	Registr MH 17 Rev 1/2		OONIA	.uui greatur ,	L'AND						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND#18, perFH, 6/18/07, DFS, MOO 1- State Registrar AMEND#17, perFH, 6/18/07, DFS, McCo Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 7:25pm 5,2007 Victor Clement Beal Jr. June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hillhaven Nursing Center Adelphi Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2/06/1931 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Min 1 → M 2 □ F Michigan 76 316-46-9713 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai", or items 23a or 28a-f show Examiner must be notified at Prince George's Md Adelphi 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3210 Powder Mill Road 20783 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ½ Yes 2 □ No 1953 If Yes, Give Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status Black, White, etc. 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 "natural", or White 1 ☐ Yes 2 🔀 No Specify ۾ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dept.of Agriculture Biometrician 7 is marked other traumatic event, t Victor Clement Beal, Sria Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Lousie Murdoch Louise Murdoch Vincent Clement Beal 2 19a. Informant's Name/Relationship (Type. Print)
Lois U.Beal/Step-mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 203 S.Luray Street Greenville, MI 48838 203 S.Luray Street 27 permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other th 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State Forest Home Cem. 6/11/2007 Greenville, Michigan 4 Donation 5 Other (Specify 21. Sign tur Mineral Service I PHILIP D.RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 Approximate Interval Between Onset and Death 23a. Part1. Enter the shock, or heart e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, it failure. List only one cause on each line. Immediate Cause (Final 6 mo. **Physician** disease or condition resulting in death) Ischemic cardiomyopathy /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed sician and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physician Completed by Physician/Medical the as attending IF FEMALE: use 23c. If ves, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy ō in the past 12 months? Month Day Year 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Parkinson's Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Lewy-Body Dementia 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy performe certificate 1 Yes 2 No Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) Injury 1 Naturai 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who com

29b. Signature and title of certifier

JUN 0 8 2007



cause of death (Item 23a) (Type, Print)

29c. License number

D0052401

29d. Date signed (Month, Day, Year) June 6,2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Sol BARSKY June 5, 2007 /Medical 6:19 A 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Bethesda Montgomery Suburban Hospital If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 93 578-46-8843 Director April 27, 1914 Washington, DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "naturai", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "naturai", or items 23a or 28a-f show idical Examiner must be notified at 1 ∑Yes 2 No Director Washington DC 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20015 United States 6317 - 32nd Street, NW Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ZYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WW II Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dentistry Dentist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rose Borow permit. Pages 1 and 2 should be Department of Health and Menta Important; If Item 27 is marked any injury or other traumatic ev Benjamin Barsky ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6317 - 32nd St., NW, Washington, DC Jeffrey Barsky, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 06/07/07 1 X Burial 2 □ Cremation 3 X Removal from State 4 □ Donation 5 □ Other (Specify) King David Memorial Garden Falls Church, VA 21. Signature of Funeral Service Licensee Torchingky Hebrew Funeral Home 20012 254 Carroll St., NW, Washington, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Aspiration Pneumonia resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy detached for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4∏Unknown Be Completed Renal Failure 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No the funeral director, page 2 autopsy perform 1□ Yes 25 2√□ No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 24 29c. License number 29b. Signature 29d. Date signed (Month, Day, Year) ပ 30. Name at address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, MD 20814 Atul Rohatgi. M.D. 31. Date filed (Month, Day, Year) 32 egistrar's Signature State Registrar JUN 08 2007

DHMH 17 Rev 1/2001

			For State Registrar	State of M	faryland		artmen rtificat			and M		jiene og. No.	17	202	8
П	Physicia	20	1. Decedent's Name (First, Middle,	Last)							<ol><li>Date of Dea Month</li></ol>	Day	Year	3. Time of	
	/Medic		Kathryn	Mur				osta			June	7	2007	8:15	A <sup>M</sup>
i.	Examin	er	4a. Facility Name (If not institution,		r)				Location o	of Death		4c. County			
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H	Funeral			5. Sex 7. A 1 ☐ M 2 🔀 F	Age (In yrs. las		Months	Days	Hours	Min.	8. Date of Birth (Month, Day	Year) 24,1921	Cour		r roreign
	Director		154-14-2898 Usual Residence of Decedent		86		L				April A	24,1921	ALI	zona	
	/land		10a. State 10b. County		10c. City,	Town or Lo	ocation						1	0d. Inside Ci	ty Limits
	Man	tor	Maryland Wash	ington	На	gerst	cown							1 🗌 Yes	2 No
	h the	Directo	10e. Street and Number				10f. Zip	Code				10g. Citizen of	What Cour	ntry?	
	th wit	aiD	13116 Fountair	Head Road	l		2	21742				USA			
deet	dee Tu	Funerai	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S. s?	13.	Was Deced	dent of His	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)		e - Americk, White,	an Indian, etc.	
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ore.	of He fiter		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Demouslifrom Sta	20b. Plac	ce of Disponentery, cre	osition (Nar	me of other place	9)	C	ate	20c. Location	City or To	own, State	
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ä	permit. Pag Depertment Important: i eny injury o once.		21. Signature of Funeral Service Li	censee		2	2. Name ar	nd Addres	s of Facilit	y Res	t Haven	Funera	1 Cha	apel	
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687	iticate g phy is the	Physician/Medical		u.							-				
Box	eath certitic attending pl	N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			7 <b>c</b> :					23d. Da	te of deliv	эгу	
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<u>S</u>	atter Dire	Certification:	4 Homicide		etc. (Specify)			,			City or Tou	m, State)			
	To the Hospital or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the tuneral director, page		29a. Certifier	Physician: To the be	st of my knowl	ledge, dea	th occurred	at the tim	ie, date an	d place,	and due to the	cause(s) and m	anner as s	tated.	
	n 24 he Fu	edical	(Check only 2 Medical E	xaminer: On the basis and manner	s of examinatio stated.	n and/or in	nvestigation	ı, in my op	oinion, dea	ith occur	ed at the time,	date and place,	and due t	o the cause(s	;) 
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	2		30. Name and address of person w	no completed cause of	of death (Item 2	23a) (Type	, Print) J			0	11			λ	/
			17th text 104 Ber	TOFORD, MI	Strar's Signatu	1708	ICAL	C/1/	TRUS	RO	14968	RSTOWN	1, M	13 21	742
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DHMH 17 Rev 1/2001

Registrar

		1 - State of Maryland / Dep	artment of Health and Mertificate of Death	lental Hygien	2000	20280
Physic	cian	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month 5 / 1 7 / 2	Year 3	. Time of Death
/Med	lical	Elsie E. Droneburg  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death	7:40 AM
Exam	iner	9933 Kelly Road	Walkersville		Frederi	c k
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	) If Under 1 Year   If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	r) Country)	e (State or Foreign
Directo	r	2 2 0 - 3 0 - 9 9 9 1 7 1 Yrs.  Usual Residence of Decedent		10/30/19	35 MD	
aryland show	_	10a. State 10b. County 10c. City, Town or L				Inside City Limits 1 ☐ Yes 2 ☐ No
the Ma 28a-f	ecto	MD Frederick Walke	rsville   10f. Zip Code	100.0	Citizen of What Country?	
3a or	i	9933 Kelly Road	21793	Tog. C		
r death	Funeral Director	11 Mas Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No~ Rican, etc.)	USA  14. Race - American I  Black, White, etc.	ndian,
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G Z filed v Hygie other t	ပို	1 2 B c	ook Keeper  18. Mother's Name	Ke (First, Middle, Maide	nn Pontia en Surname)	c Auto
riand uld be file Aental H rked oth tic even	To Be	Harry E. Routzahn Sr.	Doroth	y C. Dixo	o n	
Wary	-		ing Address (Street and Number or Rur	al Route Number, City	or Town, State, Zip Coo	de)
ore, INIC, I		Michael W. Droneburg Son 9933  20a. Method of Disposition 20b. Place of Disp	B Kelly Road Wal		e, MD 217 Location - City or Town.	
calturing rmit. Pages partment of portant: if its y Injury or o		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	or other place)		, ,	
Dalli permit. F Departm Importar any Injur	ġ	21. Signature of Funeral Service then see	22. Name and Address of Facility K e	eney & Ba	sford P.A	_мо А. F.H.
0 88 5 8	5	John but Kare M01176 1	06 East Church	St. Fred		
		23a. Part1. Effer the disease, or complications that caused the death. Do not en shock or heart failure. List only one cause on each line.  Immediate Cause (Final	nter the mode of dying, such as cardiac	or respiratory arrest,	Inte	proximate erval Between aset and Death
Physician /Medical	_	disease or condition resulting in death)  a. Due to (or as a consequence of):	ICER (METASTAT	(c)		9106
Examiner	1					
ad sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			e.	
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ate be executed hysician and the burial-transit	ical	d				
ertifica ling ph e as th		IF FEMALE:				
w requires that the death certificates signed by the attending phenough be detached for use as t	Physician/Mec	In the past 12 highlis?	☐Ectopic pregnancy		23d. Date of delivery  Month Day	y Year
the d	hysi	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown 9 ☐ Unknown	Gotto (spoon)			
es tha igned be det	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		use contribute to the ca	
w requires to been signed should be o	eted	DIAGETES		1 ☐ Yes		y 4 □Unknown
he law e has t	Completed	HYPERTENSION		24a. Was an autopsy performed?	death?	findings available etion of cause of
lan: T rtificate tor, pa	Be Co	25. Was case referred to medical	26. Place of Deat	1 Yes 2 ✓ 1 1 Yes 2 ✓ 1 1 Yes 2 ✓ 1	lo 1 ☐ Yes 2 ☐	] No
Physical rithis cerral direc	To B	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie		me 5 Residence	6 □Other (Specify)	WWW TANKEY AT MILE
aling P	ion:	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident investigation (200 Accident Section 1)	of 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe how inj	ury occurred	
Attended to death	ficat	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, s		28f. Location (Street a	and Number or Rural Ro	oute Number,
rs after al Dir	Certification:	- , , , , , , , , , , , , , , , , , , ,		City or Town, Sta		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 2 ☐ Medical ExamIner: On the basis of my knowledge, dea and manner stated and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as stated and place, and due to the	d. e cause(s)
o the vithin 2 o the	Med	one) and interest and title of continer	29c. License number	29d. D	ate signed (Month, Day	r, Year)
FSEO		1 / 10	D32171		6/18/07	
10		30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)			
	tate	RICHARD L. GOUGH AND PO	U KUN 328 WALK	हार्यास्ट	MD 2179:	3
Regis		30. Name and address of person who completed cause of death (Item 23a) (Type IZ CLUSZO L. GOUCH, MD PO 31. Date filed (Month, Day, Year) 82. Registrar's Signature JUN 2 2 2007	W)			

DHMH 17 Rev 1/2001

		•	For State Registrar	Cer	rtificate of L	Death	F	leg. No. 2007	20281
ľ	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month JUNE	19 2007	3. Time of Death
)	/Medic Examin	al -	PURNELL JAY ELBOURN  4a. Facility Name (If not institution, give street and number)  5750 S. Hawthorne Ave.	JR.	4b. City, Town, or Rock H	Location of Death	JUNE	4c. County of Death Kent	5:20 a M
	Funeral Director			rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day Mar 14	9. Birth	place (State or Foreign ntp) Tand
DESILITIOFE, INIGITY ISING ZIZIS-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	tor	1751 2751	City, Town or Loc					10d. Inside City Limits 1 A Yes 2 □ No	
	with the 3a or 28a	Il Director	10e. Street and Number 21219 Rock Hall Rd.		10f. Zip Code 2166	1		10g. Citizen of What Cou	ntry?
	urs after deatt al", or items 2 Examiner mus	by Funeral	11. Marital Status  1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🔀 No		ecify Yes or No- Rican, etc.)	_	
	within 72 ho ene. <b>than "natur</b> be <b>Medical</b> I	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give life. L	dent's Usual Occup kind of work done o DO NOT use retired DOat Eng	during most of work f)	sing	16b. Kind of Business/Ir	dustry
and 2	ld be filed lental Hygis ked other ic event, th	To Be Co	17. Father's Name (First, Middle, Last) Purnell Jay Elbourn, Sr.			18. Mother's Nam		Maiden Surname) Coleman	
, Mary	and 2 should lath and Men 127 is marke er traumatic		19a. Informant's Name/Relationship (Type. Print) Purnell J. Elbourn Sr. (f		•			r, City or Town, State, Zi, ve. Rock I	
altimore	nit. Pages 1 artment of He ortant: If Item Injury or other.		1 NP Puriol 2 Crometion 2 Personal from State	Vesley	Cemeter Cemeter	y 6/2		20c. Location - City or T	, MD.
מ	permi Depar Impor any Ir	16 5	M	10051D	118 Wes	t Cross	St. G	of Stepher alena, MD.	21635
6876U, ST	Physician and /Medical Examiner  as the pnulal-transit	al Examiner	23a, Parti. Enter the disease, or complications that caused the deshock, opheart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a constitution of the condition of th	sequence of):				Namy	Approximate Interval Between Onset and Death
O. Box 68/	death certificate leath or set of the tree of the tree of the tree of the tree of the tree of the tree of the tree of the tree of the tree of the tree of the tree of the tree of the tree of the tree of tree	Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	etal death 3	□Ectopic pregnance	,		23d. Date of deliv	very Day Year
ds, F.	w requires that the death ce been signed by the attendii should be detached for use	by	Part II. Other significant conditions contributing to death but not	resulting in the u	ınderlying cause giv	en in Part I.	23e. Did to	obacco use contribute to	the cause of death?
i Hecords	mt 00 o.i	Completed					24a. Was autop perfo 1 Yes		copsy findings available completion of cause of
VITal	Physician: The Is this certificate har ral director, page 2	Be	25. Was case referred to medical examiner?  1  Yes  No  Hospital: 1 Inpatient 2		at 3DDOA Oth	26. Place of Dea			. Parents
Vision or	Sir d	ation: To	1 Yes 2 No 1 No 1 No 1 No 1 No 1 No 1 No 1 No	28b. Time o	of 28c. Injui	4 LI Nursing H		dence 6 Other (Spec now injury occurred	Home
DIVIS	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building,	ecify)			City or Tov		
	the Hosp thin 24 hou the Fune mpletely fil	Medical	29a. Certifier (Check only one)  1	knowledge, deat nination and/or in	th occurred at the tinvestigation, in my	opinion, death occu	rred at the time,	cause(s) and manner as date and place, and due 29d. Date signed (Month.	to the cause(s)
)	N. W. C.		· WW	Hom 22c) /Tyro-		03988	7	6/11/0	7
		ate	30. Name and address of person who completed cause of death (I			ill Rd.	St 10	O Chestert	21620 <del>:own, MD</del>
	Regist	rar	MALL W YOU TO SEE SEEN OF						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 14, 2007 3:30 A M June FROUNFELTER PAULINE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Frederick Memorial Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** Months 1 □ M 2**X** F Feb. 1, 1918 Maryland 89 Director 217-10-0554 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show Examiner must be notified at 1 TYes 2 No Union Bridge Director Frederick Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or: any injury or other traumatic event, the Medical Examiner must be n 21791 10911B Green Valley Rd. U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Force Black, White, etc. ☐ Yes 2 💆 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 2 Specify. 3 Nidowed 4 Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) teller banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clarence H. Pittinger Anna Julia Fox ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Fay F. Reese/ daughter 11140 Green Valley Rd. <u>Union Bridge, MD 21791</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mountain View Cem. 6/18/2007 Union Bridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Sign ture of Funeral Service Lig Hartzler Funeral Home apparine 6 Broadway Union Bridge, MD 21791 Ε. 23a. Part1. Enter the disease, or complications that of seed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a con equence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician by Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) ned by the at a detached fo 1 ☐ Yes 2 ☐ No 9 □ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 2 No 1 ☐ Yes 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 🔲 Yes 1 Inpatient Certification: To this in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death. 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 36421 MD who completed cause of death (Item 23a) (Type, Print)

State Registrar

4

30 Name and address of person

Ridgetie

9093

2. Registrar's Signature

18 18 1

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

		4	For State Registrar	State of	Maryland		artment of H rtificate of I		_	gien Reg. N	711111	20285	
F			1. Decedent's Name (First, Middl	le, Last)					2. Date of De Month	Da	ay Year	3. Time of Death	
ľ	Physicia /Medic		Arthur John Fr	ederick					June 6		007	12:05 A M	
	Examin	er	4a. Facility Name (If not institution					Location of Death			4c. County of Death Anne Arundel		
	<u> </u>		Crofton Conval		. Age (In yrs. I	ast birthday)	Crofton If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9. Birth	place (State or Foreign	
	Funeral Director		577-22-1649	1 MM 2□ F	83	Yrs.	Months Days	Hours Min.	July 22	y, Year 2, 1	923 Wash	ington, DC	
	yland now at	- 1	Usual Residence of Decedent  10a. State 10b. County	/	10c. City	, Town or Lo	eation					10d. Inside City Limits 1X Yes 2 □ No	
	e Mar	ctor	Maryland Howar	d	Colu	mbia							
	or 28	Director	10e. Street and Number				10f. Zip Code				itizen of What Cou	ntry?	
	s 23a	eral	10101 Governor				21044	ispanic Origin? (Sp	ecify Yes or No	USA	14, Race - Ameri	can Indian,	
36	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show the the Medical Examiner must be notified at ant, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☒ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes Give	! □ No	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	Specify:	Rican, etc.)		Black, White, Specify: Whi		
21215-0036	"natura dical E	Completed	15. Deceder (Specify only highe	nt's Education est grade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work	king	16b.	Kind of Business/Ir		
121	within ene. than he Me	dmo	Elementary/Secondary (0-12)	College (1-4	for 5+)		ns Analys			Dep	artment	of Defense	
<b>d</b> 2	filed Hygi other ent, tl	Be Co	17. Father's Name (First, Middle	, Last)		L= <b>y</b>		18. Mother's Nam	ie (First, Middle				
lan	should be fand Mental I smarked ol umatic eve	70 B	Louis P. Frede	rick				Germaine	Reuter	r			
Maryland	2 shot and N Is ma		19a. Informant's Name/Relation			1					or Town, State, Zi	p Code)	
	and 2 eaith m 27 I		Valerie A. Fre	derick/ Dau		1	2 Cathead		Date		Location - City or T	ours State	
Baltimore,	Pages 1 ment of Ho ant: If Iter ury or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation				osition (Name of matory or other pla				•	own, State	
ţ			4 Donation 5 Other (		Res	surrec	tion Ceme	tery 6/9/	/U/		nton, MD	al Home	
Bal	permit. Departr Importa any inj		21. Signature of Funeral Service ticensee  22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate interval Better 100 ones the consequence of the consequ										
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that ca st only one cause on ea	used the deatl ch line.	h. Do not en	ter the mode of dyli	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a. Corona	ary Art	ery Di	Isease						
4	/Medical Examiner		resulting in death)	Due to (o	r as a conseq	uence of):							
		er	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury										
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	<b>S</b> .							is		
ó	e exec an an trial-tr	Exa	resulting in death) Last	Due to (o	r as a conseq	uence of):	_						
68760,	ficate be executed physician and is the burial-transit	edical		d									
	certific nding p	/Mec	IF FEMALE:	23c. If yes, outc	ome of predoc	ancv					23d. Date of deli	Jan.	
Box	eath atter	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bi	rth 2 ☐ Feta ant at time of d	al death 3	☐Ectopic pregnand ☐ Other <i>(specify)</i> _	у			Month	Day Year	
P.O.	that the d ed by the detached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unkno	wn								
			Part II. Other significant condit			ulting in the u	underlying cause gi	ven in Part I.		te. Did tobacco use contribute to the cause of death?			
ord	requires sen sign tould be	ted	Carcinoma Urin	ary Bladde	<u> </u>				1	] Yes	2KN0 3LPro	bably 4 Unknown	
ecc	S 5	Completed by							24a. Wa	onsv	24b. Were au prior to death?	topsy findings available ompletion of cause of	
E H	Th page	Con									No 1 ☐ Yes	2 □ No	
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medic examiner?	Heapital:		150/0-4	oti oti	26. Place of Dea			о Пон /S		
9		: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date o		28b. Time	III 3 DOA	44 Marsing □	28d. Describe		6 ☐Other (Speciality occurred	erry)	
on	Attending I r death. ector: After by the funer	tion	1 Natural 5 ☐ Pend	ling (Monti stigation	n, Day Year)	Injury		rk? ]Yes 2 ☐ No					
Division or Vital Records,	Atter or dear rector by the	Certification:	3 Suicide 6 ☐ Could	mined Zoe. Flace	of injury - At h	ome, farm, si	treet, factory, office		28f. Location City or To		and Number or Ru ate)	ral Route Number,	
Ö	ital or rs afte ral Dir led in	Cer		946					//				
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Medical	29a. Certifier 14 € Certify (Check only 2 Medical one)	ring Physician: To the al Examiner: On the ba and mann	sis of examina	owledge, dea ation and/or i	nvestigation, in my	opinion, death occ	e, and due to th urred at the time	e, date	e(s) and manner as and place, and due	to the cause(s)	
	To the within To the complete	Me	29b. Signature and title of certif	fier				se number		29d. [	Date signed (Monti	n, Day, Year)	
			1	1			13	8958		01	11/0/		
	gx)		30. Name and address of person					D	MD 210	61			
	ĮV		Daljeet Sidhu,	$\frac{\text{M.D. } 208}{\text{ar}}$	gistrar's Sign	nighwa ature	y Sw Glen	burnie,	rw 210	ΟŢ			
	Sta Regist		31. Date filed (Month On You	7 2007	me	N. A.	fresk						

07-04569

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Kirk Hinton State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) Kirk Patrick Hinton 2. Date of Death Time of Deat Physician/ Month Day June 15, 2007 0700 hrs KIRK **Medical Examiner** 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 3610 Ralph Street Road Silver Spring Montgomery If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** oreignWASHINGTON Country) Months Days Director OCT. 6 1969 217-08-1224 1 X M 2 F 37 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location 1 Y Yes 2 No or 28a-f show SILVER SPRING MONTGOMERY notified at once Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code U.S.A. 20906 3610 RALPH ROAD 23я Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 Married Yes If Yes, Give Year Specify: Widowed 4 Divorced Yes 2 No specify: BLACK ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 1. Pages 1 and 2 should be filed within 72 Firment of Health and Mental Hygiene.
rtant: If item 27 is marked other than "ry or other traumatic event, the Medical E. 21215-0036 NONE DISABLED 12th 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) ELEANOR MASON JAMES E. HINTON Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20774 B 9302 HOBART STREET SPRINGDALE, MARYLAND ELEANOR MASON/MOTHER 20a. Method of Disposition 20h. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State Baltimore, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 6/20/2007 CLINTON, MARYLAND Donation 5 Other Specify RESSURRECTION CEMETERY 21. Signature of Funeral Service Licensee J. B. JENKINS FUNERAL HOME LANDOVER, MARYLAND 20785 7474 LANDOVER ROAD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** een Onset and failure. List only one cause on each line /Medical Death Seizure disorder Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and AMENDED #23a,2/,perME,g869, #1,4a,perME,g869, 7/2/07 TI Physician/Medical X UNPENDED X e attending physician for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown ficate has been signed by the page 2 should be detached f 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? certificate ✓ Yes 2 1 🗸 Yes No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: Other<sub>4</sub> DOA Nursing Home 5 Residence 6 V Other; Scene Inpatient 2 ER/Outpatient 3 this 1 🗸 Yes No 28a. Date of Injury (Month, Day, Year) After 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: 1 X Natural 1 Yes 2 No Pending 24 hours after death the Funeral Director: mpletely filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Wedical To the 2 Wedical Examine on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 16, 2007 30. Name and ddress of person wno completed cause of death (Item 23a) OCME Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature State

Registrar

			For State	State of Ma	aryland		artment rtificate			nd M			007	2021	38	
			Registrar  1. Decedent's Name (First, Middle, Last)				incate	OIL	Catri		2. Date of Dea	eg. No.		3. Time of De	eath	
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	/Medic		4a. Facility Name (If not institution, give			<u> </u>	4h City 7	Cours or	Location of	Dogth	o di le	-	unty of Death	7:03A		
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- 49 - 35 - 35	Funeral Director			M 2⊠F	95	Yrs.	Months		Hours	Min.	Sept. 28	Year) 191	Cou	y land	or organ	
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	r 28	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizen	of What Cou	ntry?		
	1 wit		750 Green Vall	ey Rd.					2177	76			U.S.A	١.		
	deat	Funeral	11, Maritat Status	12. Was Decedent Armed Forces?	Ever in U.S.	. 13.	Was Deced	ent of His	spanic Orig	in? (Spe	cify Yes or No- Rican, etc.)	14.	Race - Ameri Black, White			
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7	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "natural; or frams 23s or 28s-f show event, I're Medical Examinar must be notified at	ပိ	17. Father's Name (First, Middle, Last)				home			r'e Namo	(First Middle			16		
Maryland 21215-0036	ntal h	Be		lakinates					TO: WIGHT		ry Mess	le, Maiden Sumame)				
Ž	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If Itam 27 is marked other then "natural", or Itams 23s or 28s-f show any Injury or other traumatic event, Ita Medical Examinat must be notified at ones.	2	William E. M  19a. Informant's Name/Relationship (Ty	·	1	19h Mailir	na Address	(Street a	nd Numbe		Route Number		wn State Zi	n Code)		
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	2	-	23a. Part1. Enfer the disease, or compl	ications that caused	d the death.								10 2177	Approximate		
			shock, or heart failure. List only or Immediate Cause (Final	ne cause on each li	ine.			, -						Onset and De	ath	
) 8	Physician /Medical		disease or condition resulting in death)	a		ERX	>							2 veer	6)	
	Examiner		1	Due to (or as										2 vee	A.,	
*		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque											
Vid	uted d ansit	min	cause. Enter Underlying Cause (Disease or injury that initiated events													
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	deatt	icia	in the past 12 mounths? 1 □ Yes 2 ☑ No	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)							Month			Day Ye	ar	
Ö.	t the by th tache	hys	9 🗆 Unknown	9□ Unknown							-	. 11				
٥,	w requires that been signed to should be det	γ	Part II. Other significant conditions co	ntributing to death b	but not result	- 11		ause give	n in Part I.		23e. Did to	bacco use	contribute to	the cause of dea	ith?	
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æ	ysician: The lav is certificete has director, page 2 (	E									perfor		death? 1 ☐ Yes	_		
ita	ician: Th certificete rector, pag	Bec	25. Was case referred to medical						26. Place	of Death	(Check only or	70)				
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io	endir sath. or: Al	atic	2 ☐ Accident investigation				М	1 🗆 \	/es 2 □ l	No						
₹	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, et	ijury - At hon tc. (Specify)		reet, factory	, office		1	28f. Location (S City or Tow	treet and N n, State)	lumber or Rui	al Route Numbe	3 <i>1</i> ',	
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07-04 Leroy

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Dhuniai		Registrar 1. Decedent's Nam	e (First, Middle	,Last)						Date of Death Month Da			Time of Death
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		4a. Facility Name (		, give street and nu	mber)		4b. City, Tow	n, or Location	n of Death		4c. County o		5
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Baltimore, permit. Pages 1 an Department of Hee Important: If iter		1/Inn.		Tood or	2	В	910 S	ilver	Hill	Řď.	Suitla	and.	Md.20746
hysicia	1	2 a Part I. Enter	r the disease, o	r complications that	caused the dea	th. Do not ente	er the mode of	dying, such	as cardiac or	r respiratory arres	st, snock, or n	eart	Between Onset and Death
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المرام المرام		events resulting	in death) Last	d.									-
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Box 68760, death certificate be the attending physici	ched for use as the burn	IF FEMALE:		23c. If ye	s, outcome of pr	regnancy			ctopic pregna	ancv	23d. Date Month		ry Day Year
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It the c	tached		gnificant conc	litions contributing	g to death but no	ot resulting in	the underlying	cause given	n in Part I.				obably 4 Unknown
Records, P.O. The law requires that th cate has been signed by	be de	<u> </u>								24a. Was			autopsy findings available
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IVISION or Attend after death. Director:	by the	2 Accide			Place of Injury -	At home, farm,	street, factor	y, office build	ting, etc.			imber or	Rural Route Number, City
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Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi	completely filled in	29a. Certifier 1		Physician: To the	best of my know	wiedge, death	occurred at th	e time, date a	and place, an	nd due to the caus	se(s) and mar	nner as s	tated.
thin 2	mplet	(Check only one) 2	✓ Medical E	Physician: To the xaminer:On the ba and mann	sis of examination	on and/or inve	stigation, in m	y opinion, de	eath occurred	at the time, date	and pidoo, o		Month, Day, Year)
F. S. F.	3	29b. Signature	and title of cer		10		29	O.C.M.I			June 15		
			My	avi,	mo			O. O. IVI.I					
		30. Name and Ling Li,		son who completed stant Medical E	cause of death ( xaminer	(Item 23a) 111 Penn S	Street, Balt	imore, MI	D 21201				
		Ling Li,		100	Registrar's Signature		1 1						

Registrar

07-04566 Mary Lease

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
WEND#10E, 19B Per FH 6/19/07 Certificate of Death OH AACO HEALTH DEPT.

Reg. No.

2007 20290

hysician Examine	Do	or State AMEND# IUE, 198 PEL FITO/ 1970	· Certificate o	, , , , , , , , , , , , , , , , , , , ,	2. Date of		34	Time of Death
Evening	,	Decedent's Name (First, Middle,Last)			Month June	Day 15, 2007	Year	0425 hrs
Examilia	er	Mary Rose Lease		4b. City, Town, or I		4c.	County of Death	
	48	. Facility Name (if not institution, give street and number		Glen Burine			nne Arundel	
		Baltimore Washington	ge (In yrs. last birthday)	If Under 1 Year		of Birth (MM/I	DD/YYYY) g. Birthp	lace (State or
uneral		Social Security Hamsel		Months Days	1.0	7/1961	Foreign Count	ry) Germany
irector	2	12-90-3612   1 M 2X F	46 Yr	rs.	372	772700		
	U	sual Residence of Decedent	10c. City, Town or Loca	ation			1	0d. Inside City Limits
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how	_	MD Anne Arundel	Odenton			10g Citi	izen of What Countr	y?
Sa-f s	윉	De. Street and Number	3	10f. Zip Code	21113	log. on	USA	
or items 23a or 28a-f show must be notified at once.	Director	193 Salton Ave. 493 Salton		1			14. Race - America	n Indian Black
23a 110ti		Marital Status     12. Was Deceder		Vas Decedent of His	spanic Origin? ( Specify Yes n, Mexican, Puerto Rican, et	s or No-	White, etc.	ar indian, bloom
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with giene her t	탕	7. Father's Name (First, Middle, Last)			18. Mother's Name (First, M		n Surname)	
THAY		Frank Korom			Yoshiko Og	ami	- 0111	7:- Codo)
permit. Pages I and 2 should be tiled within 12 hours and usual minimus rimayams. Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f sho important: If tiem 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the N. dical Examiner must be notified at once injury or other traumatic event, the N. dical Examiner.	o Be	Iga. Informant's Name/Relationship (Type, Print )	19b. Ma	Salton Av	eet and Number or Rural Ro	ute Number,	onty or Town, State,	Zip Code)
shou and N 7 is n		Raymond Lease Husband	493	Salton Av	e. Odenton,	MD ZI	. 113 c. Location - City or	Town State
nd 2 salth em 2 raum	·	20a Method of Disposition		position (Name of corother place)	emetery, Date			
s l a		1 XXBunal 2 Cremation 3 Removal from	State Nichols	Rethel Ce	emetery 6/19/	2007	Odenton,	MD
Pag nent ant: or ot		4 Donation 5 Other Specify:	Transition 12	2 Name and Addre	ss of FacilityHardest	v Fune	eral Home	P.A.
partin port		21. Signature of Funeral Service Licensee	1	2 Ridgels	Ave. Annapo	lis, M	Ф 21401	
F 7 F 1		23a. Part Fenter the disease, or complications that cause	and the death. Do not en	ter the mode of dvin	g, such as cardiac or respire	atory arrest, s	shock, or heart	Approximate Interview Between Onset an
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Amend Item 29d per dr., 268,06/22/0/drb

State of Maryland / Department of Health and Mental Hygiene 2 1 1 7

1- Registrar 24a,29d, per MD, 25,27,28a-f, per Certificate of Death Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Year LEORA MAE INMAN MILLER 10:10 PM 2001 /Medical Ma 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner RLR 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Days 176-12-4110<sup>1□ M</sup> XXF 85 Director 3-9-1922 PA. Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show rai", or items 23a or 28a-f shore Examiner must be notified at MD. CHARLES WALDORF 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2962 JONES CT. 20602 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No 21215-0036 "natural", or 1 ☐ Yes 2☐No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER <u> 12th</u> OWN HOME is marked other Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES ALLEN 2 DEBORAH ORA DAVENPORT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if Item 27 is any injury or other trau CHRISTINE MIGLIORINI-DAGHTER 11185 LORD BALTIMORE DR. SWANN POINT, ND 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 0 6 4 5 EVERGREEN CEMETERY IX Burial 2 ☐ Cremation 3 ☐ Removal from State 5-22-07 UNION CITY, PA. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 2. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MD. 20646 MOO479 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence **Examiner** CERTIFICATION ADPROVED BY MEDICAL EXAMINER Sequentially list conditions, ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (of as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has t 24a. Was an autopsy perform certificate 1∐ Yes 2 X No director, 25. Was case referred to medical Be 26. Place of Death Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes <del>2 N</del>5 ٩ 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation  $\boldsymbol{A}^{\mathsf{M}}$ 1 Yes 2 No 2 Accident subject fell out of bed May 11, 2007 unk Funeral Director: tely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Assisted Living Facility 2962 Jones Ct. Waldorf, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only within 24 h To the Fu one) 29b. Signature and tit of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 14, 2007 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) fice Rd. Walorf, Md. 20602 70 Past Of A. Abbas DM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM#29d per PHYS. G868 6/22/07 WS State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 530 PMM **Physician** 2007 Mancino 06 4a. Facility Name (If not institution, give street and number) /Medical 4c. County of Death Town, or Location of Death Examiner center MO. Ca Frederick 5. Social Security Number If Under 24 Hrs. 8. Date of Birth 5 (Month Bay, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sex **Funeral** Days Hours Months 1 ☐ M 2 🗗 F 81 227-70-5765 Director Usuat Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mentel Hygiene.
Int: if Item 27 is marked other than "natural; or items 23a or 28s-f show mit: if Item 27 is marked other than "natural; or other traumatic event, it a Medical Examinar must be notified at any or other traumatic event, it a Medical Examinar must be notified at MARTINSBURG XXYes 2 □ No BERKELEY WV by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 217 N. MAPLE AVENUE 25401 Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) OWN HOME Cottege (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) LOUISE WALLBART HONORE COLLART 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11675 FOX GLENN DRIVE, OAKTON, VA 22124 BRUCE R. MANCINELLI/SON 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition ARLINGTON NT. CEMETERY 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: if eny injury or once. ARLINGTON, VA 16, 2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN FUNERAL HOME. Chaeles m. Bi P.O. BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician androm 40 Path /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a our sequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2.☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to comptetion of cause of death? 24a. Was an autopsy performed 15eas & 1 ☐ Yes 2 ☐ No 1 Yes 2 No JAMI'C or Attending Physician: After this certification funeral director, I 25. Was case referred to medical examiner? 26. Place of Death | Check only one Be Hospital: 1 Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 No 5 Residence 6 Other (Specify) ဥ 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? 27. Manner of Death 28b. Time of Certification: 1. Natural 5 Pending 1 🗌 Yes 2 □No death. investigation 2 Accident Director: the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours after To the Funeral Dire the Hospital Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d - Dave signed (Month, Day, Year 6/15/07 29c. License number 29b. Signature and title of certifier D006041 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21702 65 c sha 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

aith Anita Magr	•	1- For State Certificate of De		⁄giene Reg. N	200	1 2029
Physicia	in/	Registrar  1. Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
ledical Exami		Faith Anita Magruder	Situ Town on Location of Do-15	Month Day June 17, 200	4c. County of Death	0441 hrs
		,	City, Town, or Location of Death linton		Prince George	's
Funeral	T	7, 7	Under 1 Year If Under 24Hrs.	8. Date of Birth (M	M/DD/YYYY) 9. Birti Foreigi	
Director		577-84-2207 1 M 2XF 37 Yrs.	Months Days Hours Min.	April (	5,1970 Col	
and the second of the second		Usual Residence of Decedent  10a, State 10b, County 10c, City, Town or Location				10d. Inside City Limits
	_	Md. PG Clinton			_	1X Yes 2 No
Maryland 28a-f show 1 at once.	Director		f. Zip Code	10g. 0	Citizen of What Coun	try?
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MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho umatic event, the Medical Examiner must be notified at once	neral	1 Never Married 2 X Married Armed Forces? If Yes, s	ecedent of Hispanic Origin? ( Sp specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ White, etc.	can Indian, Black,
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21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Richard Lowe	Sarah	Douglas		
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Baltimore, MD bernit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati	H	20a, Method of Disposition 20b, Place of Disposition		20735 Date 20	c. Location - City or	Town, State
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Division of Vital Records, P.O. Box 68760, "Get To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	(Check only one)  2 ✓ Medical Examiner: On the basis of examination and/or investigation, and manner stated.				
F. W. T.	Me	29b. Signature and title of certifier	29c. License number		9d. Date signed (Mo	nth, Day, Year)
		my hi, mis	O.C.M.E.	J	une 17, 2007	
10		30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 111 Penn Street,	Baltimore. MD 21201			
	tate					
Regis						
DHMH 17 Rev 1/2	2001	ORIGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 18, 2007 Year **Physician** 6:00 AM M Olga V. Pue /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Frederick 4b. City, Town, or Location of Death Examiner Woodsboro 11222 Woodsboro-Creagerstown Road 8. Date of Birth Feb. 25, 1911 If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M XXF 213-78-1794 96 Maryland **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits Maryland Frederick Woodsboro 1 ☐ Yes 2 XNo Director 10f. Zip Code 10g. Citizen of What Country? ns 23a or 11222 Woodsboro-Creagerstown Road 21798 U.S.A. Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 2 X No 1 Never Married 2 Married o. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: <u>م</u> Specify: White 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 7 is marked other tha traumatic event, the I Health Care Registered Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Paul Vollerthum Emma Hoev ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14950 Old Frederick Road, Rocky Ridge, MD 21778 Michael E. Pue, Jr., son item 2 20a. Method of Disposition
1 ☐ Burial 2 ACremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once, Smithsburg Crematory June 19, 2007 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal of Foreral Service Liver see Reeney and Bastord PA Funeral Home 106 East Church St., Frederick, MD 21701 MO0255 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Physician Ischemic Cardiomyopathy years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner years Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknowr 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? ģ Atrial Fibrillation page 2 should Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Wunknown Myocardial Infarction 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate rmed? 2 Z No 1∐ Yes i or Attending Physician: after death. funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation within 24 hours after ucom...

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 53129 June 18, 2007

\ 0 State 30. Name and address of person who completed c

Month, Day, Year)
JUN 2 2 2007

Dale Heitzig, MD

31. Date filed (Month

Registrar
DHMH 17 Rev 1/2001

10 Solarex Court, Frederick, Maryland 21703

use of death (Item 23a) (Type, Print)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MAY 25, 11:11 P MADALINE W. PENWELL **Physician** 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON 8. Date of Birth Month, Day, Year) 12-26-1931 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex Funeral VIRGINIA 1 □ M 2√□ F Director 233-48-6298 Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10d Inside City Limits 10b. County 28a-1 show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heatlh and Mental Hygiene.
snt: If item 27 ia marked other than "natural", or Itams 23a or 28e-1 show ury or other treumatic event, It a Medical Evand and must be notified at ury or other treumatic event, It a Medical Evand and must be notified at 1 ☐ Yes 2 No Director MARTINSBURG W۷ BERKELEY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 767 SHERIDAN AVENUE USA 25401 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? I □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married HITE Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be FRANK R. HARPINE MAUDIE HENSELL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 767 SHERIDAN AVE., MARTINSBURG WESLEY P. PENWELL, SR./SPOUSE W٧ 25401 20b. Place of Disposition (Name of Method of Disposition

1XXBurial 2 Cremation 3 Removal from State Date 20c. Location - City or Town, State permit. Page Department of Important: If any injury or once. PLEASANT VIEW MEMORY GARDENS 05-29-2007 MARTINSBURG W 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility PO BOX 821, 327 W KING STREET narles BROWN FUNERAL HOME nun MARTINSBURG WV 25402 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC LUNG CANCER /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physiclan/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): 68760, Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown CHRONIC OBSTRUCTIVE PULMONARY DISCASE 24b. Were autopsy findings available prior to completion of cause of death? ATRIAL 24a. Was an FIBRILLATION , VALUULAR KETART DISCASE autopsy performed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After Hospitel or Attanding 5 Pending investigation 1 Matural death. 1 ☐ Yes 2 ☐ No 2 Accident after death Diractor: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide thin 24 hours aft the Funerel Di mpletely filled in 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) within 2

To the complet 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mubly, Madron June 19 2007 D62562 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MADHAVI HUBBUY HAGERSTOWN MAKYLAND 21740 WASHINGTON COUNTY HOSPITAL 251 E ANTIETAM STREET 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUN 2 2 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend line 1 per phy aaco hlth dept 06/07/07 dlw State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Prachi Patel **Physician** 200 /Medical 4c. County of Death City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Hospita timore Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min 218-77-2666 Director Feb. 5,2007 Marvland Usual Residence of Decedent 10d Inside City Limits 10a State 10h County 10c. City, Town or Location "natural", or items 23a or 28a-f show dical Examiner must be notified at XXYes 2 □ No Director Maryland | Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21403 United States 986 Spa Road, #201 Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify:Indian-Asian 2 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hr. Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natur any injury or other traumatic event, the Medical. once. Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Urvashi Hitesh Patel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 986 Spa Rd.,#201, Annapolis, Maryland Hitesh Patel/Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 □ Cremation 3 Removal from State Hillcrest Mem.Gardens 6/6/07 Annapolis, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home Sign & re of Funeral Service Lite 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cldays Physician Irau matic brain Injury due to Mater Venico Hecident Ford Hallann /Medical Due to (or as a consequence of): Examiner Se pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER and burial-tran Due to (or as a consequence of) Box 68760, attending physician for use as the buria pe Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a detached f 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ş 2 🗆 **X**lo 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 Yes 2 No funeral director, 26. Place of Death (Check only one, Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ After this 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Date of Injury (Month, Day Year, 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 X No 07 death. 2 Accident 3 Suicide within 24 hours after death To the Funeral Director: completely filled in by the i 6 ☐ Could not be 4 ☐ Homicide Apartment Condex Taking of 186 Son Kond Annapolis Mo

1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RALTIMEE MARYLAND GOO NORTH WOLFS STREET WILLIAMSON 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Charles Frederick Rupert 11:45 A M 2007 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Future Care Chesapeake Arnold Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1**⊠** M 2□ F 70 213-34-5995 Director Feb. 14, 1937 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at Edgewater Maryland Anne Arundel 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21037 87 Stewart Drive, #407 U.S.A. items 23a Funeral 14. Race - American Indian. Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Examiner filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 K No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Tractor Trailer Driver Transportation 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 12 should be fi and Mental F is marked oth Elmo Catherine Smallev Arthur Edwin Rupert ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at
Important: If Item 27 is
any injury or other trau Kathryn Rupert/wife 87 Stewart Drive, #407 Edgewater, Maryland 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Mem. Gardens 6/9/2007 Annapolis, Maryland 4 Donation 5 Dother (Specify) 21. Signature Honeral J rv Licensee 22. Name and Address of Facility John M. Taylor Funeral Home V 147 Duke of Gloucester St., Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) preumonia **Physician** days /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed and the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 2 □ No Ö 9 I Inknown 9 Unknown signed by ď Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ robably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 pade certificate 1 | Yes Vital 25. Was case referred to medical examiner? Physician: funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 1 Yes 2 No 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3□ DOA o After this 27. Manne Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Injury at Work? Certification: Division or Attending 1 V atural Injury 5 Pending 1 Yes 2 No death. investigation 2 Accident the 1 within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 ☐ Homicide filled Hospital intifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 1 Varifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tuy M. llersv. lle Mi

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 0 7 200

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 12:43 AM **Physician** 2007 June ppeon VIara /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Janus Hopkins Hospital 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year 6. Sex 5. Social Security Number **Funeral** Days Hours 1 □ M 2 🕱 F 10,1930 Maryland Nov. 76 Director 215-26-2020 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10h County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Frederick Maryland | Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21703 7088 Catalpa Road Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify. White ģ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 Ith and Mental Hygie 27 is marked other traumatic event, # other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mental H Gladys Horton Theodore Esworthy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 and Department of Health ar Important: If Item 27 is any injury or other trau 7088 Catalpa Road, Frederick, Maryland 21703 John W. Rippeon Sr./Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 6/13/2007 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Memorial Gardens Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral 22. Name and Address of Facility Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2 weeks acq uired Ventricular Septal **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Majorardial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to ( s a consequence of): ner LINKHOWIN Exami Due to (or as a consequence of): a (teru that initiated events resulting in death) Last physician and s the burial-tran Physician/Medical the 88 attending IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? ō 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Tes 2 No 3 Probably 4 Unknown Coaquilatio disseminated Intravascular Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No 1 Yes Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide

Box 68760, Division or Vital Records, P.O.

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

certificate be executed nours after death.

neral Director: After this filled in by the funeral di ö To the Hospital within 24 hours a To the Funeral C

State Registrar

Medical

4 Homicide

(Check only

29b. Signature and title of certifier

29c. License number

1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

North Wolfe Street Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2007 ear Day June **Physician** Francisco Roa, Sr. 5 8:30A. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's 4007 Hillwood Court Beltsville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 ☐ F El Paso, Texas 68 Director 450-64-9735 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location Beltsville 10d. Inside City Limits 10a. State 10b. County Maryland Prince George's 1 ☐ Yes 2 No r 28a-f sh notified Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral", or items 23a or Examiner must be 20705 4007 Hillwood Court United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 Married 'natural", or 3altimore, Maryland 21215-0036 1∭XYes 2☐No Specify: Specify: White Mexican þ 3 ☐ Widowed 4 ☑ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 7 Is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Custodian Calvert Co. Schools 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Felipe Roa Luz Romero ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 4007 Hillwood Court Beltsville, Maryland 20705 Arturo Roa -son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If II any Injury or o 1 Burial 2 Acremation 3 Removal from State Metropolitan Crematory 6/7/2007 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 21. Signature of Funeral Service Licens e eun romas 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician OSTEONYELITIS OF LUMBOSACRAL /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending phy IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) ed by the a detached f 9☐Unknown has been signed le 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2**1** No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed?

1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate ha 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 ☐ Yes No မ 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: Injury 5 Pending ours after death.
neral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗀 Homicide within 24 hours a To the Funeral C completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State Registrar

anyares care pro

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



29c. License number D16619 29d. Date signed (Month, Day, Year)
June 6, 2007

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend 28d, perME, e868, 6/20/07 II/06/2I/07 24a per me e666116

State of Manyand / Department of Health and Manhal Hygiene

Amend Items 25,27,28a-f per me, 8668,06/08/07dinb

Reg. No.

Reg. No. - State Registrat 23a Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** MARIAN V. SCHAECH 1:24 AMM April 2007 /Medical 21 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death The Pines Talbot Genesis HealthCare -Easton | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | Mar 27 1925 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign
Country) **Funeral** Months Days 1 ☐ M 2 🕱 F Yrs 219-22-0633 Director 82 Maryland Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at 1 XYes 2 No MD Talbot Easton Funeral Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 700 Port St. 21601 U.S.A. or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. I ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Marian Schaech 1 ☐ Yes 2 X No Specity: Specify: White Š 3 ₩ Widowed 4 Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages I and 2 should be filed win Department of Health and Mental Hygient Important: if Item 27 is marked other than eny Injury or other treumatic event, that once. Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John C. Vojik Mary Businsky 9 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jo Papin (daughter) 5112 North Dr. Cambridge, MD. 21613 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State St. Mary's Cemetery 4/27/07 Pylesville, MD. 4 □ Donation 5 □ Other (Specify) 21. Signature Freneral Service Li Galena Funeral Home of Stephen L. Schaech M00510 118 West Cross St. Galena, MD. 21635 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cayse (Final disease or cerdition resulting in death)

a. Due to (or as a consequence of): Approximate Interval Between Onset and Death Death **Physician** /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): Examine burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 Tes 2 No Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ mind 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy 1 ☐ Yes 🔭 No Hospital or Attanding Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes - ANO ဥ this After the 28d. Describe how injury occurred Passenger
Subject driver of a car that

28f. Location (Street and Number of Augustions of Augu 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 5 Pending investigation eftar death.

Director: Aff 1:34 P M 1 ☐ Yes 2 No 03/04/2003 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide Roadway within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (ROWLEY 610 WD DOT MICHAEL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

			1_ State	partment of Health and Neartificate of Death		2007	20301
			Registrar  1. Decedent's Name (First, Middle, Last)	ertificate of Death	2. Date of Deat	eg. No. C U U /	3. Time of Death
	Physici			rier	Month June	Day Year 8 2007	8:00 A <sup>M</sup>
	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Julie	4c. County of Death	
	LXumii	<u>.</u>	Golden Living Center	Frederick		Freder	ick
ı	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days Hours Min	8. Date of Birth (Month, Day,	Year) 9. Birth	nplace (State or Foreign untry)
	Director		214-10-5243 1⊠M 2□F 91 Yrs	. Working Buyo Troute William	Sept. 5	, 1915 Ma	ryland
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Maryli fsho led at	JO.	Maryland Frederick Frede	riole			1. X Yes 2 □ No
	the 28a-	Director	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Co	untry?
	h with		30 North Place	21701		United S	tates
	deat	Funeral		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Amer Black, White	ican Indian,
õ	or ite		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☒ No Specify:	Thours, c.c.,		hite
5-0036	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	d by	3 ☑ Widowed 4 □ Divorced Year or Dates: WWII				
င်	n 72 "nat	lete	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of work e. DO NOT use retired)	ing	16b. Kind of Business/I	naustry
717	withi iene. • than	Completed	Elementary/Secondary (0-12)   College (1-4or 5+)	vy Equipment Operat		Excavati	ng
0	illed Il Hyg other	BeC	17. Father's Name (First, Middle, Last)			Maiden Surname)	8
yland	uld be Menta Irked Itic ev	To B	Roscoe Conklin Spurrier	Mary A	gnes La	yman	
Mar)	2 sho and I is ma auma		19a. Informant's Name/Relationship (Type. Print) 19b. Ma	ailing Address (Street and Number or Rui	al Route Number	r, City or Town, State, Z	ip Code) 21793
	and lealth m 27 her tr			4 Inspiration Avenu			
galtimore,	ges 1 If of H If ite or otl		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	crematory or other place) June	2 16,	20c. Location - City or 1	
	t. Pa rtmen rtant: rjury					Frederick,	
g	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signut re of uneral Service Licensee	22. Name and Address of Facility Sta 1621 Opossumtown Pi			
	_	_	23a. Part1. Enter the disease, or complications that caused the death. Do not				Approximate
	Physician		shock, or heart failure. List only one cause on each line.			,	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a, Due to (or as a consequence of):	-ADDER MALIGNA	NCY		
	Examiner		FAILURE	TO THAIVE			
4	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	5			
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C				
8/60,	death certificate be executed e attending physician and d for use as the burial-transit		Due to (of as a consequence of).				
200	icate phys s the	dical	d				
ROX	e law requires that the death certif has been signed by the attending je 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy			, 23d. Date of deli	very
ň	death e atte	icia	in the past 12 months?  1 Ves. 2 No.  4 Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)		Month	Day Year
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'n	requires that the een signed by th nould be detache	by F	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		bacco use contribute to	
ecords,	requir		J		1 🗆 Y	es 2 No 3 Pro	obably 4 🗗 Unknown
Š	elaw rasb e2sh	Completed			24a. Was a autops	prior to o	topsy findings available ompletion of cause of
Ž a	Th ate pag	So			perform 1□ Yes	med? death? 2. No 1 ☐ Yes	2 <b>1</b> 0 No
VITAL	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Deat			
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0	th. :: Afte	tion	1 ☑Natural 5 □ Pending (Month, Day Year) Injui	ry Work? M 1 ☐ Yes 2 ☐ No		,,	
UNISION	Atter	ifica	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (St City or Town	treet and Number or Ru	ral Route Number,
5	tal or s afte al Dir ed in	Certification:	Tuliding, etc. (Specify)		City of Town	ri, State)	
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier (Check only)  1 ☑ Certifying Physician: To the best of my knowledge, dr 2 ☐ Medical Examiner: On the basis of examination and/o	eath occurred at the time, date and place, r investigation, in my opinion, death occur	and due to the c	ause(s) and manner as	stated. to the cause(s)
	the I	Medical	one) and manner stated.  29b. Signature and title of certifier	29c. License number			
	<b>2</b> € 6 0		29b. Signature and title of certifier	D 4795		9d. Date signed (Month	
<i>p</i>	AVI		30. Name and address of person who completed cause of death (Item 23a) (Type				
E	T		SIBTE A KAZMI, TO 814 TO	u House Ave.	FREDE	reick Mn ?	21701
	Sta	te	31. Date filed (Month, Day, Year) 32 legistrar's Signature	1			
	Registr	ar	JUN 1 1 2007 James & A	gode .			

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 17:06 PM 06 2007 Virginia W. Snyder /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicimico LENTER KENINSULA KEGIGNAL MEDICAL ALISBURY Date of Birth (Month, Day, Year) 5/28/1927 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number **Funeral** Virginia Months Days Hours Min. 1 M 2 X F 226-30-3298 80 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show 10a. State r 28a-f show notified at 1 Yes 2 No Director Sanford Virginia Accomack 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number r than "natural", or items 23a or the Medical Examiner must be 23426 USA 9017 Snyder Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify Specify: ģ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker 12 should be filed w h and Mental Hygieu 7 is marked other ti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked of any injury or other traumatic ew Grace Trader ပ Tillery White 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9017 Snyder Lane Sanford, VA 23426 Edward Snyder/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Buria! 2 ☐ Cremation 3 ☐Removal from State Groton's Cemetery 6/13/07 Hallwood, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Liçensee 22. Name and Address of Facility Thornton Funearl Home 24183 Chadbourne St. Parksley, Virginia 23421 23a. Fart1. Enter the disease, or commendations that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 20 /Medical Due to (or as a consequence of): Examiner Se pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-tran Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1☐Yes 2₽\$No Day 4□Pregnant at time of death 5 Other (specify) ned by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Junknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 TYes Division or Vital funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral is 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Acciden 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 (Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

ORIGINAL

erson who completed cause of death (Item 23a) (Type Print)

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

0 6

5B

State

Registrar

29b. Signature and title of gertifier

30. Name and address of

31. Date filed (Month, Day,

JUN 12

		-	For. State Registrar	State of Maryla	•	artment of He rtificate of D			giene Reg. No.	007	20303
Ph	ysicia	an	1. Decedent's Name (First, Middle, Last					2. Date of Dea		O 7 Year	3. Time of Death
//	Medic	al	Ernestina	Siguenza		4b. City, Town, or	Location of Dooth	June !	5, 2°0	County of Death	4:45a м
Ex	amin	er	4a. Facility Name (If not institution, give Prince George s			Chever					eorge's
Fun Dire	eral ctor		5. Social Security Number 6. Se		rs. last birthday) 1 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Date 1 / 24 /	h y, Year) 194	9. Birthp	place (State or Foreign htry) Salvador
and w			Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	ocation					0d. Inside City Limits
ie Maryla 8a-f sho	tified at	ctor	MD Montgor			Spring					1 ∐Yes 2∏ No
th with th	ust be no	Funeral Director	10e. Street and Number 1423 Chilton Di	rive		10f. Zip Code 209	04			zen of What Cour El Salv	•
er dea items	ner m	nue	11. Marital Status 1   ↑ Never Married 2   Married	12. Was Decedent Ever in Armed Forces?	1 U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No- Rican, etc.)	. 1	<ol> <li>Race - Americ Black, White,</li> </ol>	
urs aft	Exam	þ	3 ☐ Widowed 4 ☐ Divorced	1 ∐ Yes 2XX No If Yes, Give Year or Dates:		1⊠Yes 2□No E.]	Specify: Salvado	oren		Specify: Wh	ite
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filed the street of the street	ent, t	Becc	17. Father's Name (First, Middle, Last)	unobtai	nable		18. Mother's Name	(First, Middle,	Maiden	Surname)	
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ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If flem 27 is marked other than "natural", or items 23a or 28a-f show	er traum		19a. Informant's Name/Relationship (7) Alba Gomez/Dau	ghter	142	ng Address <i>(Street a.</i> 3 <b>Chilto</b>	n Drive				·
permit. Pages 1 and 2 Department of Health a	or oth		20a. Method of Disposition 1  ☐ Burial 2 ☐ Cremation 3 ☐ I	20l Removal from State	b. Place of Dispo cemetery, cre-	osition (Name of matory or other place		ate		cation - City or To	
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permit. Departn	any Ir		Illy Dine	IV-	9	241 Colu	MDia Bl	runer vd.Sil	ver	SERVICE Spring	E,P.A. g,Md20910
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the done cause on each line.	eath. Do not en	ter the mode of dying	g, such as cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
Physic /Med			Immediate Cause (Final disease or condition resulting in death)	a. Pneum							Onoct and Boats
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Hospital or Attending Physician: The law requires that the death certific 24 hours after death.  Funeral Director: After this certificate has been signed by the attending I	ched for use	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome pf pre 1 □Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)			2	3d. Date of delive Month	ery Day Year
w requires that the d	e deta	by Pt	Part II. Other significant conditions co	entributing to death but not	resulting in the u	nderlying cause give	n in Part I.	23e. Did to	obacco us	se contribute to t	he cause of death?
require sen sig	d bluo		Chronic renal f	ailure				101	res 2	No 3∏ Proi	pabiy 4 Unknown
The law te has be		Completed	Cerebral infar						rmed?	24b. Were auto prior to co death? 1 □ Yes	psy findings available mpletion of cause of
Physician: The la	ctor, p	Be	Gangrenous bowe 25. Was case referred to medical examiner?	51			26. Place of Death	1 Yes (Check only o	2 <b>∑</b> No ne)	I li res	Z[] NO
Physic this ce	al dire	은	1 ☐ Yes 2 No		ER/Outpatier		4 LI Nursing Hor				(y)
ding Ph	Φ	tion:	27. Manner of Death  1 ▼Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time o	Work	at ? ∕es 2 ∐No	28d. Describe h	now injury	occurred	
l or Atten after deat Director	l in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - A building, etc. (Spe	t home, farm, sti ecify)			28f. Location (S City or Tox	Street and vn, State)	d Number or Rura	al Route Number,
To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft	letely filler	edical C	29a. Certifier 1 ★ Certifying Phy (Check only one)	rsician: To the best of my iner: On the basis of exam and manner stated.	knowledge, deat nination and/or ir	h occurred at the tim vestigation, in my op	ne, date and place, a binion, death occurre	and due to the ed at the time,	cause(s) date and	and manner as s place, and due t	stated. o the cause(s)
To th within To th	дшоо	Me	29b. Signature and title of certifier	i mas		29c. License	number 026024			e signed (Month, e 5,20	
2		-	30. Name and address of person who c	ompleted cause of death (I	Item 23a) (Type,	Print)					
			Lester Miles	MD. 649	90 Lar	ndover Ro	oad Lar	ndover	,Md.	20785	
Re	Sta egistra		31. Date filed (Month, Day, Year)  JUN 0 8 20	32. Jegistrar's Si	gnature	all!					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 200**7** Month Physician 17. 12:05 p Mary Lee Thompson June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 520 West Main Street Middletown Frederick If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Nov 8, 1938 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In vrs. last birthdav. Funeral Months Days 1 □ M 2 🗓 F 219-44-4720 68 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show notified at Pennsylvania Adams Fairfield 1 XYes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Important; if item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be it 209 West Main Street 17320 U.S.A. Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 No Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical/Health Care Transcriptionist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be finance and Mental H Be Virginia Wright William Burke Nettie John မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 209 West Main Street, Fairfield, PA 17320 1 and 2 s Health ar Mrs. Robin Laumann, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages ' Department of H 1 Burial 2 Cremation 3 Removal from State Smithsburg Crematory Jun 21, 2007 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Keeney & Basford P.A. Funeral Home
106 East Church St, Frederick, Maryland 21701 21. Sign ture of Funeral Service Licens 16 Ben M00706 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Lun Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed the burial-transit and Due to (or as a consequence of) physician Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal dea 4 □Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy 2 Fetal death Year Month Day 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Jas 1□ Yes 2 🔀 No funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Daughter's Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this Home 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: n 24 hours after death.

ne Funeral Director: A
pletely filled in by the ft within 24 hor To the Fune completely fi the

> State Registrar

Hemen Shah, M.D., 65-C Thomas Johnson Drive, Frederick, Maryland 21702 32. Registrar's Signature 31. Date filed (Month, Day, Year) 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signatura and title of certifier



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D60417

29d. Date signed (Month, Day, Year)

June 18, 2007

For Amend #8 per FH/FHYS Mary land 10 Oppartment of Health and Mental Hygiene Registrer Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 4:50 June 10 2007 Norma Ε. Turner /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Lorien Life Center Mt. Airy Carroll 1928 9. Birthplace (State or Foreign Country)
Washington, DC If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🕅 F 579-24-8811 79 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other then "netural", or items 23e or 28e-f show other treumstic event, the Moulcal Experies fraust be notified at 1⊠Yes 2□No Director Maryland Mt. Airy Carrol1 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 713 Midway Avenue Apt. 201 21771 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🖾 No Specify Specify: Completed by 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within : th and Mental Hygiene. 7 Is marked other then " Elementary/Secondary (0-12) College (1-4or 5+) Jewelry Store Sales Clerk 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 is marked any injury or other treumetic events. Harold Harmon Harriet Babington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Damascus, Maryland 20872 Joyce Stone / Daughter 28505 Woodview Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition June 11, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 2007 ` 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Fu 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final L CELL CANCOR Physician disease or condition /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner use as the burial-transit and Division of Vital Records, P.O. Box 68760, the attending physician Attending Physicien: The law requires that the death certificate be Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? should be detached for Month 5 Other (specify) 4☐Pregnant at time of death 2 1010 9☐ Unknown 9 Unknown been signed by ontributing to death but not resulting in the underlying 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No completely filled in by the funeral director, page 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 3□ DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of After Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Funerel Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certified State Registrar

				tate of Maryla	•			lental Hy	giene		
			1 - State Registrar  1. Decedent's Name (First, Middle, Last)		Cei	rtificate of	Deam	2. Date of Dea	Reg. No. 2	07	3. Time of Death
	Physici		1. Decedent's Marie (1 hot, Middle, Edoly	IDELLA	TYLER			Month		Year 7	2:14 P M
	/Medio Examin		4a. Facility Name (If not institution, give street		0.1	_	r Location of Death	ourc	4c. County o	f Death.	
	<u></u>	A	5. Social Security Number 6. Sex	MASICE!	rs. last birthday)	If Under 1 Year	1/ <i>1SbUN</i> If Under 24 Hrs.	8. Date of Birt		2MIC	lace (State or Foreign
В	Funeral Director		220–12–0202		Yrs.	Months Days	Hours Min.	June 10,	v. Year)	Coun	rland
			Usual Residence of Decedent	140-	O't. T.						
	faryla show ed at	ō	Maryland Somerset	100.	City, Town or Lo	Crisfield				1	0d. Inside City Limits 1 ☐ Yes 2 X No
	the N 28a-i	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	hat Coun	itry?
	th with 23a or Ist be	al Di	3463 State Street				21817		U.S	.A.	
	r deal	Funeral	11. Wartar Otatas	Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race Black	- Americ White,	
36	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	by Fi		1 ∐ Yes 2 🙀 No f Yes, Give Year or Dates:		1 □ Yes 2 ☑ No	Specify:		Specify:	Whit	.e
21215-0036	2 houral attural cal Ex	ted	15. Decedent's Education	on	16a. Dece	dent's Usual Occup	pation		16b. Kind of Bus	iness/Ind	dustry
215	thin 7 ie. ian "n Medi	Completed	(Specify only highest grade con Elementary/Secondary (0-12)	College (1-4or 5+)			during most of work d)		Local Bu		
121	be filed within 7 ital Hygiene. d other than "n event, the Medi		10 17. Father's Name ( <i>First, Middle, Last</i> )		Secre	etary	19 Mother's Nam		Seafood  Maiden Surname		ers Union
Maryland		o Be	Vernon E. Tawes				Cecil C	,	walden Surrame	7	
ary	2 should and Men Is marke aumatic	2	19a. Informant's Name/Relationship (Type.	Print)	19b. Mailii	ng Address (Street	and Number or Rui	ral Route Numbe	er, City or Town, S	tate, Zip	Code)
	is 1 and 2 should of Health and Mer item 27 Is marke other traumatic	3	Linda Warfield (Daug				Road - J				1084
ore	iges 1 nt of H If ite or otl		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo	ival from State I	-	osition (Name of matory or other place		Date	20c. Location - C	•	
altimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature → Strength Service Acensee			Memorial Page 12. Name and Addre			Crisfie	εтα,	MD
Ba	Dep Imp		Robert H. Bradsha	W Jr.	Br  30	radshaw & )6 W. Main	ss of Facility Sons Fun n St Cr	eral Ho isfield	me , MD 21	817	
T.			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one care	ons that caused the dause on each line.	eath. Do not ent		ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	(D)	RONAR	y AFT	ERY VI	STASE			Onset and Death
1	Examiner			Due to (or as a cons	sequence of):						
	A F	ner	Sequentially list conditions, flags, cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons	sequence of:						
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9	tificate ig phys as the	ledical	a						= = p = = =		
Вох	leath certific attending p for use as	an/N		lf yes, outcome pf pre 1□Live birth 2□F		∃Ectopic pregnancy	y		23d. Date Mont		ery Day Year
O.	requires that the death certifii een signed by the attending I nould be detached for use as	Physician/Me	1 Ves 2 No	4□Pregnant at time ∈ 9□Unknown	of death 5[	Other (specify)		-	Mon	ur	Day real
Δ.	that the poly the pol		Part II. Other significant conditions contributions	uting to death but not	resulting in the u	nderlying cause giv	ren in Part I.	23e. Did to	obacco use contrib	oute to th	ne cause of death?
Vital Records,	w requires been sign should be	ed by						1 🗆 1	res 2□No 3	∃ ☐ Prob	ably 4 dnknown
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<b>Xit</b>	Physician: this certificral director,	Be C	25. Was case referred to medical examiner?  1  Yes 2 No Hosp	ital: 1 Inpatient 2	⊇ ∏ ER/Outpatier	nt 3 DOA Oth	26. Place of Deat				
100		n: To	27. Manner of Death 2	8a. Date of Injury	28b. Time o				lence 6 □Other now injury occurre	1-7	y)
sior	Attending r death. ector; Afte	atio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			M 1 🗆	Yes 2 □ No				
Division	or Att after de Direct in by	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	8e. Place of injury - A building, etc. (Spe	t home, farm, str ecify)	reet, factory, office		28f. Location (S City or Tow	Street and Number vn, State)	r or Rura	il Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 Certifying Physicia								
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	with To	Σ	29b. Signature and title of certifier			29c. Licens	6536		29d. Date signed	(Month,	
			30. Name and address of person who compl	eted cause of death ()	Item 23a) (Type				W 10	0/	
E	В		K Webberg 100	East CA	PROLL S	STREET.	Salishur	y mo	2180		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death

the burial-tran

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month  $A^{\ M}$ 2007 2:15 June 16, WILLIAM 0 WERTENBAKER 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Sex Months 1 X M 2 □ F 213-12-7061 86 MD 2/24/1921 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Tyes 2 No MD Frederick Walkersville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21793 USA 104 Dunford Court 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after cent of Heatth and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or iter
Iny or other traumatic event, the Medical Examiner
Iny or other traumatic event, the Medical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Property Inspector Maryland Nat. Guard 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William O. Wertenbaker Sr. Myrtle B. Myers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Elsa Roeder 104 Dunford Ct. Walkersville, MD 21793 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town. State 1 Bunal 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Olivet Cem. 6/19/2007 Frederick, MD 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Funeral Service Licensee Ka M01176 106 East Church St. Frederick, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 5 DAYS PNEUMONIA /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Division or Vital Records, P.O. Box 68760, 😿 Due to (or as a consequence of): Physician/Medical attending ph for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown CHRONIC OBSTRUCTIVE PULMONARY Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an LUNG CANCER autopsy
performed?

1 Yes 2 No this certificate har al director, page To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA ို eral Director: After th filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D32171 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD L. GOUGH MD PO Box 328 WALKERSVILLE 22. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Catherine Frances Wloszek Αм June 6 2007 6:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis Eldercare Spa Creek Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🔀 F 110-22-6193 79 Director July 16, 1927 New York Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f shov notified at 1 Yes 2 No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a or edical Examiner must be 14 Ellington Drive 21403 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Completed by White 3℃Vidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation event, the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Crossing Guard City of Annapolis 8 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be file treent of Health and Mental H tant: If Item 27 is marked oth jury or other traumatic even Be Ross Simons Florence Kapperman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Cox/daughter 915 Monroe Manor Road Stevensville, MD 21666 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) MD Veterans Cemetery 6/11/2007 Crownsville, Maryland 21. Signature of Faheral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final mohoma **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month 4□Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð pe 1 🗌 Yes 2√ No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1∐ Yes 1 ☐ Yes 2 No 2 No or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 Tes 2 🗆 No after death. the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital or within 24 hours af To the Funeral D Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier

31. Date filed (Month, Day State Registrar

tuavt

Selonich, mo Year) strar's Signature JUN 0 7

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Best pake Rd. Annapolis, Md.

			1 - State State Registrar	of Maryland	•	artment of H Stificate of I		Mental Hy	giene Reg. No. 20	17 20309
	Physici		1. Decedent's Name (First, Middle, Last)  Loretta Lucia Wils	son				2. Date of De Jun •	eath Day Y	3. Time of Death 007 12:50 a <sup>M</sup>
	/Medic Examir		4a. Facility Name (If not institution, give street and	number)		4b. City, Town, or	Location of Death	1	4c. County of	Death
		×	634 Robinson Stat:			If Under 1 Year	Severna If Under 24 Hrs.			Arundel
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. Ia 41	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da Apr. 2	7, 1966	). Birthplace (State or Foreign Country) MD
	land bw tt		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	a-f sh	ctor	MD Anne Arundel		Se	verna Par	k			1 □Yes 2 No
	with the 3a or 28 t be not	I Director	10e. Street and Number 634 Robinson Station	Road		10f. Zip Code	21146		10g. Citizen of Wh	at Country?
980	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 Married   12. Was D Armed   1 □ Ye   ecedent Ever in U.S Forces?		Vas Decedent of H f Yes, specify Cuba □ Yes 2 No		pecify Yes or No o Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. White	
21215-0036	be filed within 72 ho ital Hygiene. id other than "natur event, the Medical."	Completed	15. Decedent's Education (Specify only highest grade complete  Elementary/Secondary (0-12)  College	d) e (1-4or 5+)	16a. Deced (Give life, L	lent's Usual Occup kind of work done o OO NOT use retired Homemak	during most of wor l)	king	16b. Kind of Busin	ness/Industry
Maryland 2	ould be filed Mental Hygi larked other latic event, the	To Be Co	17. Father's Name (First, Middle, Last)  Vincent Ralph Capitell	-0			18. Mother's Nan	ne (First, Middle Schiavon	, Maiden Surname) •	
ary	유 전 E E	F	19a. Informant's Name/Relationship (Type. Print)		19b. Mailin	g Address (Street	and Number or Ru	ıral Route Numb	er, City or Town, St	ate, Zip Code)
	1 and 2 Health a em 27 is		Wayne Wilson/Husband	les D						ark, MD 21146
Baltimore,	a: 0		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)			sition (Name of natory or other place Heaven Ce	_ Cui	Date 7, 007	20c. Location - Ci	orings, MD
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Fungral Service Licensee	lhe	Ba 49	Name and Address rranco & 5 Gov. Ri	Sons, P.	A. Seve	rna Park rna Park,	Funeral Home MD 21146
			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of	at caused the death. n each line.	Do not ent	er the mode of dyin	g, such as cardiad	or respiratory a	arrest,	Approximate Interval Between Onset and Death
À.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	MIEta	- 100	tic B	reast	CHI	icer	Lyear
E	Examiner			to (or as a conseque	ence of):					0
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	to (or as a conseque	ence of):					
	xecute and !-trans	Examiner		to (or as a conseque	ence of):					
68760,	ficate be executed physician and s the burial-transit	dical E						<del></del> .		
Box (	The law requires that the death certifica te has been signed by the attending pt tage 2 should be detached for use as the same of the same as the same tage 2 should be detached for use as the same same as the same same same same same same same sam	Physician/Med	in the past 12 months?	outcome pf pregnan e birth 2 □ Fetal o egnant at time of dea known	death 3□	Ectopic pregnancy Other (specify)			23d. Date of Month	
s, P.O	res that I igned by be detac	by Ph	Part II. Other significant conditions contributing to	death but not result	ting in the ur	nderlying cause give	en in Part I.	23e. Did	tobacco use contrib	ute to the cause of death?
ord	w require been sign							1 🗆	Yes 2 No 3	☐ Probably 4 ☐ Unknown
Il Records,		Completed						24a. Was auto perfo 1□ Yes	psy prio	ere autopsy findings available or to completion of cause of ath?  Yes 2
Vital	Physician: The this certificate	Be	25. Was case referred to medical examiner? 1  Yes 2 No Hospital: 1		:D/O:	t 3 DOA Othe	26. Place of Dea	11		
o	ding Phys h. After this funeral dii	tion: To	27. Manner of Death 28a. Da		R/Outpatien 28b. Time of Injury	28c. Injur	4 Linursing H		dence 6 Other	1 7 77
Division	To the Hospital or Attending P within 24 hours after death.  To the Funeral Director: After t completely filled in by the funera	Certification:	3 Suicide 6 Could not be	ace of injury - At hon ilding, etc. (Specify)	ne, farm, str				Street and Number wn, State)	or Rural Route Number,
	e Hospita 24 hours e Funeral	ledical C	29a. Certifler (Check only one)  Certifying Physician; To 2 Medical Examiner: On the and medical Examiner:	the best of my know e basis of examination	rledge, death on and/or in	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	and due to the urred at the time	cause(s) and mann , date and place, an	ner as stated. d due to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	11 85	F	29c. License	e number		29d. Date signed (	Month, Day, Year)
	1 -11	U	Many DUN	Bross	10,	Ho	05402	5	06-0	04-2001
	C/B	Υ	30 Name and address of person who completed of MARY BETH GRO	12, D.O.	źза) (Туре, 860		ans Hwa	1, Ste	111, M	illersvillemD
	Sta Registi		31. Date filed (Month, Day, Year)  JUN 0 7 2007	Pristrar's Signatu	ure K	Carles		J /	/	21108

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Marylan		nt of Health and te of Death	, ,	iene	20310
		П	1. Decedent's Name (First, Middle, Las	t)			2. Date of Death	h Day Year	3. Time of Death
	Physici /Medio		Richard Dar	niel Walker				6, 2007	9:00 P M
	Examin		4a. Facility Name (If not institution, give		4b. Cit	y, Town, or Location of Deat		4c. County of Death	
	Funeral Director		219-54-0151		last birthday) If Und Months	Frederick or 1 Year   If Under 24 Hrs Days   Hours   Min.		Frede Year) 9. Birthr Cour 1948 We	rick place (State or Foreign ntry) st Virginia
	pu s		Usual Residence of Decedent  10a. State 10b. County	10c Cit	y, Town or Location				Od. Inside City Limits
	within 72 hours after death with the Maryland jiene. I than "natural", or Items 23a or 28a-f show The Medical Examinat must be notified at	'n	,		y, rown or Location				XXYes 2 □ No
	8a-1	Director	Maryland Frederic	ck F	rederick				
	vith t	Dir	10e. Street and Number		10f. Z	ip Code	10	ng. Citizen of What Cour	ntry?
	ath v	Funerai	506 Boysenberry			21703		United St	
	e de me	nue	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Was Dec If Yes, sp	edent of Hispanic Origin? (S ecify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White,	
36	or l	y F	1 Never Married 2 Married	1XXYes 2 ☐ No If Yes, Give	1 ☐ Yes			Specify:	
Ö	ural"	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:				Whi	te
21215-0036	72 h	Completed	15. Decedent's Ed (Specify only highest grad		16a. Decedent's Us (Give kind of w	rork done during most of wo	rking	16b. Kind of Business/In	dustry
2	within ene. than "	ш	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	ŕ		n. n. 1.	ъ.
			17. Father's Name (First, Middle, Last)		Police		me (First, Middle, M	City Police	лерт.
Maryland	tal o	Be						naiden Sumame)	
Ë	should to nd Ment marked umatic	J.	Dwight Walker			Wilma I			
<u>la</u>	2 shot and les m		19a. Informant's Name/Relationship (7			ss (Street and Number or Ru			
	s 1 and 2 should Health and Mer tem 27 is marke other traumatic		Roberta Walker /		The second secon	Drive, Apt. A		stown, Mary	
0	0 0 = =		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	1 0	lace of Disposition (Ne emetery, crematory or		e 12,	20c. Location - City or To	own, State
Ē			' 4 ☐ Donation 5 ☐ Other (Specify		ky Gap Vet		2007 F	lintstone,	Maryland
Baltimore,	permit. Pag Department Important: any injury once.		21. Signature of Juneral Service Licen-	see,				Funeral Homo	
<b>a</b>	205 20		THE STATE OF THE S	to	1621 (	)possumtown P	ike Fred	erick, Mary	land 21702
	Physician		23a. Part1. Enter the disease or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	olications that caused the death one cause on each line.	n. Do not enter the mo	ode of dying, such as cardia	c or respiratory arre	st,	Approximate Interval Between Onset and Death
8760,	Medical Examiner  physician and the burial-transit  the burial-transit	licai Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence to consequence)  Due to (or as a consequence to consequence)	uence of):	Pulme	Agration &	en 60 Mars	1 mags
.O. Box 6	The law requires that the death certificate be executed ite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregna 1□Live birth 2□Fetal 4□ Pregnant at time of de 9□ Unknown	death 3 Ectopic			23d. Date of delive Month	ery Day Year
rds, P	quires that n signed b	by	Part II. Other significant conditions co	ontributing to death but not resu	ulting in the underlying	cause given in Part I.	23e. Did tob	acco use contribute to th s 2 No 3 ☐ Prob	
Records,	The taw requir ate has been si page 2 should I	ompieted					24a. Was an autopsy perform	prior to conded?	psy findings available mpletion of cause of
Vital		O	25. Was case referred to medical			GC Diago of Day			2 No
$\equiv$		o B	examiner?	Hospital:	ED/Outpotions 200	Othor	ath (Check only one		
o	Phys r this ral di	-	27. Manner of Death		ER/Outpatient 3☐ D	OA 4 Nursing F	28d. Describe ho	nce 6 Other (Specification)	y)
U <sub>C</sub>	ding Ph h. After th funeral	tion	Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No		,,	
Division	l or Attending after death. Director: After I in by the funer	ertification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, facto		28f. Location (Str. City or Town,	eet and Number or Rura State)	I Route Number,
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edicai C	29a. Certifier (Check only one) Certifying Phy	/sician: To the best of my knowiner: On the basis of examinat and manner stated.	wledge, death occurre tion and/or investigation	d at the time, date and place n, in my opinion, death occu	a, and due to the ca arred at the time, da	use(s) and manner as si te and place, and due to	ated. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier		25	9c. License number	29	d. Date signed (Month,	Day, Year)
}	- SHO		1120000	0- m3-16	(Im r	171727	3 1	12/27	
	JAK					0.7073		7017	- Lo. A -
1	411		30. Name and address of person who of		123a) (Type, Print)	854T=	11 Hm.	L A1-	TIEAD)1
	-01-	to			ture		11 112/	Je I Va	ma
	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 1 2	32. Signat	& Sports				

State of Maryland Department of Health and Wental Hygiene 1 - For State Ragistrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 11, Day 2007 Year **Physician** 5:55 PM M Virgie Irene Young /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick College View Center Frederick If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6 / 9 / 1 9 2 8 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 💢 F 212-24-5970 MD Director 79 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Intern 27 ie marked other then "natural", or items 23s or 28s-f show 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County if Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23s or 28s-f show other traumatic event, the Mcdical Examinar must be notified at 1 Yes 2 No Completed by Funeral Director Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21701 31 East 6th Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2∑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Efementary/Secondary (0-12) Coflege (1-4or 5+) Own Home Home Maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sarah E. Crum Marion S. Ridgley ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Atty 22 W. 2nd St. Frederick, MD 21701 George T. Horman 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ permit. Page Department of Importent: if any injury or once. Mount Olivet Cem. 6/14/2007 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) Keeney and Basford PA Funeral Home MKA 106 East Church St., Frederick, MD 21701 M01176 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final stroke Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. First Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) P.0. 9 ☐ Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes ,2 No Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, Other: A Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification; To 1 | Yes 2 | No in is 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1-Natural 5 Pending To the Hospital or Attenditional within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0060417 SMA 30. Name and address of person who come eted cause of death (Item 23a) (Type, Print) Frederick Shah Phison DV 65 C ihamas 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of Maryla	-	artment of I			iene og. No.2 0 0 7	20312
	Physici		Decedent's Name (First, Middle, Last)	Lillian	Ida YOU	NG		2. Date of Dear Month June 7.	Day Year	3. Time of Death 4:50 A
	/Medic Examin		4a. Facility Name (If not institution, give str	eet and number)		4b. City, Town,	or Location of Deat		4c. County of Death	
	LAGIIII	ici	5225 Pooks Hill Roa	d #1720N		Bethe	sda		Montgo	mery
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	ff Under 24 Hrs Hours Min.		9. Birth	nplace (State or Foreign
	Director		067-12-7391	1 2 □ F   8	Yrs.	WOTETS Days	TIOUIS IVIII.	Sept. 2,		York
	۵ ,		Usuaf Residence of Decedent  10a, State 10b, County	100.0	ity, Town or Lo	nation				10d. Inside City Limits
	arylan show	2	Maryland Montgome		Bethes	. 11			}	1 ☐ Yes 2 ☒ No
	28a-f	ecto	10e. Street and Number	- 9		10f. Zip Code		1	0g. Citizen of What Co	intry?
	with a or	Funeral Director		4 #1720N		208	1 /		United Sta	
	eath	era	5225 Pooks Hill Roa	. Was Decedent Ever in	J.S. 13.	Was Decedent of	Hispanic Origin? (S	Specify Yes or No-	14. Race - Amer	
10	iter dea	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No		If Yes, specify Cub	oan, Mexican, Puer	to Rican, etc.)	Black, White	-
036	urs a	þ	3  Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 211 No	Specify:		Specify: W	nite
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or items 23e or 28e-f show the Macifel Exercities must be malified at	Completed	15. Decedent's Educa (Specify only highest grade of	tion	16a. Dece	dent's Usual Occu	pation during most of wo	rking	16b. Kind of Business/l	ndustry
215	thin 7	ple	Elementary/Secondary (0-12)	Colfege (1-4or 5+)	life.	DO NOT use retire	ed)	9		
21	e filed within all Hygiene. I other than vent, the M	Co		4	Dent	al Hygie	1		Dentistry	
nd	d off	Be	17. Father's Name (First, Middle, Last)					me (First, Middle, I	Maiden Sumame)	
yla	should nd Men	၉	Meyer Letvin		1			y Barr	O: T	. 0. 4.)
Maryland	C1 00 == 0		19a. Informant's Name/Relationship (Type Gary Young, Son	, Print)		-		Gaithers	City or Town, State, Z	1000e) 20882
a)	of Heelth of Heelth other tre		20a. Method of Disposition	20b.					20c. Location - City or	
Baltimore,	H it		M☐ Burial 2 ☐ Cremation 3 ☐ Rer			sition (Name of matory or other pla				
를	permit. Pages Depertment of Important: If I any injury or one		4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Sequical Identities				ery 06/		Adelphi, M	J
Ba	permit. Pages Depertment of h Important: If ite any injury or of							Funeral		00010
			23a. Part1. Enter the disease, or complica	tions that caused the dea	ath. Do not ent	er the mode of dy	ing, such as cardia	c or respiratory arr	ngton, DC	20012 Approximate
			shock, or heart failure. List only one Immediate Cause (Final	cause on each line.		ance				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a con s		ance				
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		Je.	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of):					
	cuted	Examiner	Cause (Disease or injury that initiated events c.							
Ó	ite be executed ysiclen and ne burial-transit	Ä	resulting in death) Last	Due to (or as a conse	quence of):					
8760,	3 5 6	Ilcal	d.							
68 ×	leath certifical ettending phi i for use as th	Mec	fF FEMALE:							
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregion         1 ☐ Live birth 2 ☐ Fe	al death 3	Ectopic pregnanc	у		23d. Date of defi Month	very Day Year
o. _	at the de by the e stached f	Physician/Med	1 ☐ Yes 2 X No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown	death 5L	Other (specify) _				
۵.	that the ed by detac		Part II. Other significant conditions contr	buting to death but not re	sulting in the u	nderlying cause g	ven in Part I.	23e. Did tol	bacco use contribute to	the cause of death?
Records,	86 69	d by	•	•		, , , , , , ,		1 🗆 Y	es 2□No 3□Pro	obably 4 Unknown
Ö	w require been si should t	Completed						24a. Was a	n 24h Were au	topsy findings available
Rec	has ge 2	d E						autops	ned? prior to death?	completion of cause of
		e Co	25. Was case referred to medical				OS Plana of Da	1 ☐ Yes : ath (Check only on	No 1 ☐ Yes	2 No
Ξ	Physician: this certific ral director,	o B	eyaminer?	spitaf: 1 ☐ fnpatient 2 [	☐ FR/Outpatier	nt 3 DOA O	hor		ence 6 ☐Other (Spec	infv)
	a Physical controls	<b>-</b>	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o				ow infury occurred	
io	Attending Fir death. ector: After by the funer	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day 1 ear)	Injury		Yes 2 □No			
Division		Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Pface of Injury - At building, etc. (Spec		eet, factory, office		28f. Location (Si City or Town	treet and Number or Ru n, State)	ral Route Number,
Ö	rs after ei Dire	Cer			,,					
	To the Hospital or within 24 hours after to the Funeral Dir completely filled in		29a. Certifier 1 Certifying Physic (Check only 2 Medical Examine	ian: To the best of my kr	nowledge, deat	h occurred at the t	ime, date and plac	e, and due to the curred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	the hin 24 the F	Medical	one)	and manner stated		1	ise number		9d. Date signed (Monti	
	CON KA	-	29b. Signature and title of certifier	$\nearrow$ 1.	201		2207		6/7/	) 7
•	15		10000	0 1			1101	2	0///	/
			30 Name and address of person who com	- /			shington	. DC 200	107	
	Sta	to	Shakun Malik, M.I. 31. Date fifed (Month, Day, Year)	32 egistrar's Sign		roau, wa	SHTHREOH	, 10 200		
¥	Registr		JUN 08 2007			and I				

		For State Registrar	State of Marylar	•	artment of H rtificate of L			giene Reg. No.	07	20313
Physici		1. Decedent's Name (First, Middle, Las	t)	A.	nato		2. Date of Dea	Day	Year 2007	3. Time of Death
Examin		4a. Facility Name (If not institution, give Mercy Hospital  5. Social Security Number 6. Se		s. (ast birthday)	Baltimore If Under 1 Year	Location of Death	8. Date of Birt	Baltim	9. Birthpl	ace (State or Foreig
Director		213-40-1486   Usual Residence of Decedent	□ M 2 🔀 F 62	Yrs.	Months Days	Hours Min.	June 14,		Maryla	nd
Marylan a-f show ified at	tor	Maryland Howard	10c. C Laur	ity, Town or Lo e ไ	cation				10	d. Inside City Limi 1 √1 Yes 2 □ N
h with the 23a or 28 st be not	al Director	10e. Street and Number 942 Canterberry Riding	j		10f. Zip Code 20723			10g. Citizen of U.S.A.	What Count	ry?
within 72 hours after death with the Maryland speed. I chan "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in I Armed Forces? 1   Yes 2   No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 Й No	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Ra Bla Speci	ice - America ack, White, e	tc.
filed within 72 hou I Hygiene. other than "nature ent, the Medical E	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)	conpleted)  College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired state Agent	during most of work f)	ing	16b. Kind of E		ustry
be filed ntal Hyg id othe event,	Be	17. Father's Name (First, Middle, Last)		Nou'l E	State right	18. Mother's Nam				
C 6 5 5	To	Lorenzo Amato 19a. Informant's Name/Relationship (7		1	ng Address (Street a	and Number or Rui	ral Route Numb			Code)
Pages 1 and 2 tent of Health nt: If item 27 I ry or other tra		Werner Crocker/Husband  20a. Method of Disposition  1 □ Burial 2 【Cremation 3 □  4 □ Donation 5 □ Other (Specify	20b. Removal from State		anterberry sition (Name of matory or other plac tory	ce)	Date /2007	yland 20 20c. Location Catons		
permit. Pages Department of I important: If ite any Injury or of		21. Signeture of Fundal Service Licen	to the same of the	22	2. Name and Addres		Sandy Sp	ring RD L	_aurel,	MD 20707
The law requires that the death certificate be executed to the law requires that has been signed by the attending physician and age 2 should be detached for use as the burial-transit and a second by the detached for use as the burial-transit.	edical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate sauce. First U. J. of the properties of the proper	a. Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.)  Due to (or as a consect.)	equence of):	bren	st car	Ler			
rne deatn certific y the attending pl ched for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregi 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal déath 3[	□Ectopic pregnancy □ Other (specify)	/	2 227		ate of delive	ry Day Year
quires that the de n signed by the a uld be detached f	by	Part II. Other significant conditions of	ontributing to death but not re	esulting in the u	nderlying cause give	en in Part I.		obacco use co Yes 🔎 No		e cause of death ably 4 □Unkno
	Completed	25. Was case referred to medical					1□ Yes	psy ormed2 2 No	prior to cor death?	osy findings availandletion of cause
this aldir	To Be	examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 25	ER/Outpatie		4 LI Nursing H	ome 5 Resi	dence 6 □O		1)
or Attending iffer death. Director: After in by the fune	Certification:	1 Natural 2 Accident 3 Suicide 4 Homicide  2 Pending investigation 6 Could not be determined	(Month, Day Year)	Injury home, farm, str	M 1	k?" Yes 2□No		Street and Nun		l Route Number,
lo the hospital within 24 hours a To the Funeral completely filled	Medical C		ysician: To the best of my kininer: On the basis of examinand manner stated.							
To the Hy within 24  To the Ficomplete	Me	29b. Signature and titlerof certifier	MD		29c. Licens	e number		29d. Date sign	1	Day, Year)
8		30. Name and address of person who	completed cause of death (lite	em 23a) (Type,	Print) P	1-	Balti.	no n	213	~03
Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32 Registrar's Sig	natura A	anti					

			For State Registrar	State of Maryla		artment of F <i>rtificate of</i>			giene Reg. No. 0 0 7	20314
	Physici	an	1. Decedent's Name (First, Middle, La	st) A-P	MAK	IAZ		2. Date of Dea	ath Year	3. Time of Death  11: 30P M
1	/Medio	cal	4a. Facility Name (If not institution, giv		7. 17 170		r Location of Deat	JUNE -	4c. County of Dea	
	Funeral Director		217-40-3261		al s. last birthday) Yrs.	Columb: If Under 1 Year Months Days		(Month, Day		thplace (State or Foreign puntry)
	land w t		Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or Lo	cation				10d. Inside City Limits
	Manyi a-f sho fied a	tor	Maryland Howard	E	llicott	City				1 ☐ Yes 2 ☑ No
	ith the or 28g	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	ountry?
	eath w is 23a nust I	Funeral	12171 Mt. Albert	Dr. 12. Was Decedent Ever in	115 131	21042	lienanie Origin? (9	Specify Ves or No-	USA 14. Race - Ame	erican Indian.
980	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		f Yes, specify Cub I ☐ Yes 2√∑ No	Specify:	Specify Yes or No- to Rican, etc.)	Black, Whi	e, etc.
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life. I	lent's Usual Occup kind of work done DO NOT use retired	pation during most of wo d)	orking	16b. Kind of Business	/Industry
	e filed val Hygie other t		12 17. Father's Name ( <i>First, Middle, Last</i>	<b>4</b>	Ма	nager	18. Mother's Na	me (First, Middle,	Hotel  Maiden Surname)	
ılan	uld be Mental rked c	To Be	Stanislau	Yanovich	,		Tatia	na	Miski	na
, Maryland	1 and 2 should it Health and Men em 27 is marke em tranmatic	·	19a. Informant's Name/Relationship ( Peter Bernazky		I	-			nr, City or Town, State, MD 21046	Zip Code)
altimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other		20a. Method of Disposition 1 → Burial 2 → Cremation 3 →	Removal from State	-	natory or other pla	The second second	Date	20c. Location - City or	
<u>=</u>	permit. Pa Departmen Important: any Injury once,		4 Donation 5 Other (Special 21. Signature of Funeral Service 1.28			rk Cemeto		7/07   oudon Pai	Baltimore k Funeral	
Ba	Depar Depar Impor any Ir	( )s							more, MD 21	
2	Physician		23a. Part1. En - disease, or com sho or heart failure. List only lumic diate Cause (Final	plications that caused the de one cause on each line.		er the mode of dying	ng, such as cardia	c or respiratory ar	rest,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a cons			a- t	2 /8 0	_	
b	Examiner	L.	Sequentially list conditions,	b. CONGEST	1 VE	1704	27 17	to care		
$\Box$	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	SEVERE	CAR	Sion	487	A714		
9	ficate be executed physician and is the burial-transit	al Exa	resulting in death) Last	b. Due to (or as a cons  Due to (or as a cons  Due to (or as a cons  Due to (or as a cons	equence of):	hemi	4 Low	35.		
09289	lificate g phys as the	edical		d				,		
P.O. Box	res that the death certi igned by the attending be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome pf preg 1 □ Live birth 2 □ Fo 4 □ Pregnant at time o 9 □ Unknown	etal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	livery Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions	contributing to death but not r	esulting in the u	nderlying cause giv	ren in Part I.	23e. Did to	obacco use contribute t ′es 2  No 3  P	o the cause of death?
Vital Records,	o -c o	Completed								utopsy findings available completion of cause of
/ita	sician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of De	ath (Check only o		
	di S	은	1 ☐ Yes 2 ☐ No  27. Manner of Death	Hospital: 1 Inpatient 2  28a. Date of Injury	ER/Outpatier		4 ∐ Nursing i	I	lence 6 Other (Speciow injury occurred	ecify)
on	Attending Physician: r death. ector: After this certific. by the funeral director,	tion	1 Natural 5 Pending 2 Accident investigatio	(Month, Day Year)	Injury	Wor	k? Yes 2 □ No	200. Describe II	ow injury occurred	
Division or	i Çirle	Certification:	3 Suicide 6 Could not be determined			eet, factory, office		28f. Location (S City or Tow	itreet and Number or R vn, State)	ural Route Number,
	e Hospital 24 hours a e Funeral l	Medical C		nysiclan: To the best of my k miner: On the basis of exam and manner stated.						
	To the within 2 To the complex	Me	29b. Signature and title of certifier	yms		29c. Licens	e number 395		Date signed (Mon	
	to		30. Name and address of person who	completed cause of death (H	em 23a) (Type,	Print) RE	NETTO DE TO	# 55 anop a	Has.	21201-
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** M 2007 Barbara F. Arnold June 21, 0642 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 14400 Butternut Court Rockville Montgomery If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 1 F 577-52-2503 70 July 21, 1936 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a.4 a.c. any linury or other traumatic event, the Medical E. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Directo Maryland Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14400 Butternut Court 20853 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry W. Fearnow 2 Ruth Beagaent 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Roger L. Arnold / Husband 14400 Butternut Court, Rockville, MD 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park June 26, 2007 Rockville, Maryland 22. Name and Address of FacilityRobert A. Pumphrey Funeral Home/Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 21, Signature of Funeral Service Licensee Rockville, Rockville, M01473 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic Heart Disease /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter U.Jerhing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy nis certificate has been signed by the atte I director, page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 🕱 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 🖾 Residence 6 Other (Specify) Certification: To 1 X Yes 2 ☐ No 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred s after deu. 1 🛮 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

filled in by within 24 hours at To the Funeral D

State Registrar (Check only

29b. Signature and title of certifier

JUN 2 5 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1201 Seven Locks Road M.D Ira Berger, 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Rockville, Maryland 20854

29d. Date signed (Month, Day, Year)

June 21, 2007

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D44157

07-04766
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Johi	n Walter Bed		, Jr. State of Maryland / Department of 1-For State Certificate of Registrar		d Mental Hy	giene <sub>Reg.</sub>	No. 200	7 2031
	Physici	an/	Decedent's Name (First, Middle,Last)		2	2. Date of Death Month	Day Year	3. Time of Death 2006 hrs
Me	dical Exami	ner		h City Town or	Location of Death	June 22, 20	4c. County of Deati	
			7 Hammock Trail	Middle Rive			Baltimore Cou	
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Yea		8. Date of Birth	MM/DD/YYYY) 9. Bir Foreig	
	Director		217-94-8536 1XM 2 F 42 Yrs.	Months Day	s Hours Min.	6/16/	1965 CC	<sup>buntry)</sup> Maryland
	ly.		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	on				10d. Inside City Limits
	1 Iow any E.							1 Yes 2 X No
	ith the Maryland 23a or 28a-f show notified at once.	Director	Maryland Baltimore Middle Riv	er 10f. Zip Code		10g	. Citizen of What Cou	ntry?
	the Mg 1 or 28 iffied	Dire	7 Hammock Trail	21220		rı	. S. A.	
	with ms 23; be not	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	s Decedent of His	spanic Origin? ( Spe n, Mexican, Puerto F	cify Yes or No-		ican Indian, Black,
	or ite	Fun	1 X Yes 2 No			dican, etc.)		
	rs after ural",	by	15 December 15 Education (Specific only high part grade completed) 16a December	Yes 2 No	specify:	ork done 1	Specify: What has been some some some some some some some some	nite
	2 hour	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)		e. DO NOT use retire			***
	036 ithin 7 sne. r than Ledica	mpl	12 Labore	er			Tradesman	
	15-0 illed w Hygie d othe	ပ	17.1 ather 3 Name (1 113t, Widdle, East)		18.Mother's Name (			
	21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	o Be	John Walter Becker, Sr.  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing	Address (Stre	Tylatta et and Number or Ru		radka er, City or Town, State	e. Zin Code)
	MD 2 shou alth and 1 m 27 is r	-		Gouah St			Maryland	
	e, land I and Healti		20a. Method of Disposition 20b. Place of Disposi	ition (Name of ce	emetery,	Date	20c. Location - City o	Town, State
	Pages nent of nnt: Il		4 Donation 5 Other Specify: HOLLY Hil	1 Mem. C	Gard. 200	25 07	Middle Riv	er, Marylan
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Licensee 22. N	ame and Addres	s of Facility	l Home P	Α	rland 21221
		. 13	23a. Part I. Enter the disease, or complice Most that caused the death. Do not enter the	07 Old F	astern Av	venue E	ssex, Mary	Land 21221 Approximate Interval
	Physician / Medical		failure. List only one cause on each line.	ic mode or dying	, oddir do odraido or	- copilatory arras	,, -,, -,, -,, -,, -,, -,, -,, -,, -,,	Between Onset and Death
	Examiner		Immediate Cause (Final disease or condition resulting in death)  Arcotic intoxication  Due to (or as a consequence of):					1
		L	Sequentially list conditions, b					-
		Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated					
	od sit	xar	events resulting in death) Last  Due to (or as a consequence of):		-			
	50, te be executed ysician and burial - transit	edical	MUNPENDED AMENDED 77 280-f novME 086					
7	60, ate be a hysicia e buria	Medi	AMENDED #23a,27,28a-f, perME,g86	<u>9, 7/10/0</u>	7 TT		23d. Date of delive	<u></u>
1	6876 certificate nding phy se as the t	sician/M	23b. Was decedent pregnant in the past 12 months?	tal death 3	Ectopic pregnar	псу	Month	Day Year
	Box 6876( c death certificate the attending phy ed for use as the b	/sic	4 Pregnant at time of death 5 Ott	her (Specify)		<del></del>		
	O. B( at the de 1 by the a	, Phy	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause	given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
	ords, P.O.  we requires that the as been signed by the should be detached.	d by				1 Yes	2 No 3 Pro	bably 4 🗸 Unknown
	ords w requ is been shoulk	Completed				24a. Was ar autops	y prior to	utopsy findings available completion of cause of
	Reco	l mo				perform 1 <b>Y</b> Yes 2		es 2 No
	Division of Vital Records, P.O tat or Attending Physician: The law requires that to safter death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted.	Be C	25. Was case referred to medical examiner?		e of Death (Check of Other)			
	f Vit Physic er this ral dir	2	1 Yes 2 No Inpatient 2 ER/Outpatient		T Hursing		esidence 6  Othe	r: Scene
	on of National Physics After the funeral	io ::	1 Natural 5 Danding (Month, Day, Year)	1	Yes 2 X No	unk	,,	
	risior r Attend ter death irector: n by the	ertification	2 Accident Investigation Investigation Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street	) Dill	- 11	28f. Location (St		ural Route Number, City
	Div ours aft eral D	erti	3 Suicide 6 X Could not be determined (Specify) found at ho	me		or Town, Sta 7 Hammock	Trail Middl	e River, MD
41	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	ical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur one) 2 W Medical Examiner:On the basis of examination and/or investigat	red at the time, d	date and place, and on, death occurred at	due to the cause the time, date a	(s) and manner as sta nd place, and due to t	ted. he cause(s)
	To To Com	Medical	and manner stated.  29b. Signature and title of certifier		se number		29d. Date signed (M	
			Potrallon in - Pollate in	o.c	.M.E.		June 23, 2007	
•	6		30. Name and address of person who completed cause of death (Item 23a)					
	0		Patricia Aronica-Pollak MD. Assistant Medical Examiner	111 Penn S	Street, Baltimore	e, MD 21201		
	S Regis	tate trar		enels)				
D	HMH 17 Rev 1/2		DOME ORIGINA	L				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 13:39 BREHM JOSEPH 2007 JUNE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE BAYVIEW MEDILAL CENTER JOHNS HOPKINS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 7, 1932 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Days 1**∑**M 2□F unk 74 Director 216-32-9677 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d, Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD 1 ☐ Yes 27 No Baltimore Baltimore **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 201 St. Helena Avenue 21222 USA 12. Was Decedent Ever in U.Sunk 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Specify: white Completed by 3 Widowed 4 □ Divorced 16a Decedent's Usual Occupation 16h Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) unk (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) unk unkunk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Be ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other tra once. Johns Hopkins Bayview Hospital 4940 Eastern Avenue Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5▼Other (Specify) in state 21. Signalura Funeral Service Licensee Konald S. W 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 Wade Director 655 W. Baltimore Street 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARRHYTHMIA **Physician** /Medical Due to (or as a consequence of): Examiner CARDIAC DISEASE Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, Examine law requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for t Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autonsy perform certificate 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours a er deat e Funeral Lirector: 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier within 24 hor To the Fune completely f (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Said, mb 4940 BALTIMORE, MD Eastern JUN 2 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) June 21, Day 2007 **Physician** Roy Macon Carlton 9:21 Ам /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 930 Kinwat Avenue Essex Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year if Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 13, 1927 7. Age (In yrs. last birthday) **Funeral** Days 1**X** M 2□ F 215 22 3936 Director Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County 28a-f show ns 23a or 28a-f shov must be notified at 1 ☐ Yes 2 No Maryland Baltimore Essex Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 930 Kinwat Avenue 21221 USA items 23a by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: ₩W II 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married White Saltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 XNo Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Detergent Mfg. Manufacturing Engineer nt of Health and Mental Hyg If item 27 is marked other or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lola B. Wilson Robert H. Carlton 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 930 Kinwat Avenue Essex, Maryland 21221 Wanda Carlton (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department or Important: If i any injury or once, Holly Hill Mem. Gardens 6/25/2007 Baltimore, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 Fight 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Heso Heliuma Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter this property Cause (Disease or injury that initiated events Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5XX Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation Injury 1 X Natural after death. 1 Yes 2 Accident 6 Could not be determined 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Thomicide

Division or Vital Records, P.O. Box 68760.

State Registrar

within 24 hours a

To the Funeral I

completely filled

29a. Certifier (Check only one)

29b. Signature and Atle of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Franklin Sq. Dr. St. 2200 Balton

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2007 Cook William Robinson 2:55PM June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 1 Smeton Place, #1401 Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Davs | Hours | Min. (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months Days 1X M 2 □ F 76 Yrs. 215-28-5732 1930 June 26, Maryland Director Usual Residence of Decedent permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2XX No Directo Maryland Baltimore Towson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1 Smeton Place, #1401 United States 21204 Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 💆 No Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) education/music teacher/musician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paul Cook Roda Robinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Towson, MD 21204 Nedra Cook/wife Smeton Place, #1401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Green Mount Crematory June 20,2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility edefeld Funeral Home, Inc. 21. Signature of Funeral Service Licensee 6500 York Rd. Baltimore, MD a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ACUTE MYOCARDIAL INFARCTION **Physician** /Medical Due to (or as a consequence of): Examiner CORONARY MATERY DISTASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine HYPELLIPISEMIA Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ OBSTRUCTIVE PULLIONALY DISTAST CHRONIC 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe rmed? 2 No 2□ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work?

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Box 68760, Division or Vital Records, P.O.

Baltimore, Maryland 21215-0036

Certification: To 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 - Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Medical 29c. License number 29b. Signature and title of certifier Alrend KNola us D0025010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) # 100 PARKVICE, MD SCRENT R. NOLAN, MA 8831 SATYL HILL RD 21234

State Registrar

32. Registrar's Signature 31. Date filed (Month, Play, Year)

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2007

07-04063 Thomas Carter

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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ledical Exami		Thomas Carter Month Day Year 0302 hrs	1									
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Funeral Director		5. Social Security Numberunk 6. Sex 1 Nage (In yrs. last birthday) 53 Yrs. If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State Qunk Foreign Country)										
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re, M 1 and 2 Health Fitem 2		20a. Method of Disposition	٦									
Baltimore, permit Pages I an Department of Hee Important: If ite		4 Donation 5 X Other Specify: in state										
Bal permi Depar Impo		21. Signature of Funera Service Licensee Ronald S. Wade, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201										
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on of \ ending Phy ath.  or: After the	tion: T	27. Manner of Death  1 Natural  1 Pending  28a. Date of Injury May 27, 2007  28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No  28d. Describe how injury cccurred Bicyclist hit by a car										
Division of Vital Records, pital or Attending Physician: The law require mass after death.  eral Director: After this certificate has been si filled in by the funeral director, page 2 should be	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Major Road / Highway  28e. Place of Injury - At home, farm, street, factory, office building, etc. 4 Homicide (Specify) Major Road / Highway  28f. Location (Street and Number or Rural Route Number, City or Town, State)  West Bound Rt. 50, West Ocean City, MD	7									
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours abredeath.  The Finneral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the	edical Ce	4 Homicide (Specify) Major Road / Highway West Bound Rt. 50, West Ocean City, MD  29a. Certifier (Check only)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	111									
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		Cal-ut 0.C.M.E. May 29, 2007										
		30. Name and address of person who completed cause of death (Item 23a)  Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201										
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20	ficate phys s the	edical		1											
מסא	n certi	N/U	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, o	utcome pf preg	nancy	75-4				23d. Da	te of delive	ry		
מ	iaw requires that the death certificate as been signed by the attending physic should be detached for use as the	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	in the past 12 months?  1							Month Day Year				
	at the i by th stache	Phys	9 Unknown'												
Š,	res th	ρχ	_	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown				
ecords,	requi	eted	UN KNOWN										99.915		
ř	'sician: The law s certificate has t irector, page 2 s	Completed							24a. W. au pe 1⊟ Yes	topsy rformed?		prior to cor death?	psy findings available npletion of cause of		
VIII K	ysician: is certifica director, p	Be C	25. Was case referred to medical examiner?					26. Place of D	eath (Check onl		'		7		
- -	Physician: r this certific ral director,	To E	1 Yes 2 No			ER/Outpatier		4 LI Nursing	Home 5□Re				/)		
VISION	nding Phys th. :: After this e funeral di	tion:	27. Manner of Death  1 Autural 5 ☐ Pending 2 ☐ Accident investigation	28a. Dat	e of Injury onth, Day Year)	28b. Time o Injury	Work	y at k? Yes 2 ∐ No	28d. Describ	e how inju	ry occur	red			
NIS	or Atter fter dea Director in by th	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Plac buil	ce of injury - At ding, etc. (Spe	home, farm, sti cify)	eet, factory, office			(Street ar Town, State		er or Rura	l Route Number,		
_	spltal ours a seral I	O	29a. Certifier 1 Sertifying Phy	sician: To the	ne best of my k	nowledge, deat	h occurred at the tin	ne, date and pla	ce, and due to t	he cause(s	and ma	anner as st	rated.		
	To the Hospital or Attending Physwithin 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	Medical	(Check only 2 Medical Exam	ner: On the	basis of exami unner stated.	ination and/or in	vestigation, in my o	pinion, death oc	curred at the tin	ne, date an	d place,	and due to	the cause(s)		
	To You	2	29b. Signature and title of certifier	/C.	ing		29c. License	o number	26	29d. Da	te signe	d (Month, i	Day, Year)		
7	30		30. Name and address of person who c	ompleted car	use of death (It	em 23a) (Type,	29c. License  DOC  Print)	<i>(</i> ·		701	<u>.                                      </u>		, , ,		
		ta.	31. Date filed (Month, Day, Year)		Registrar's Sig	ANE pature	Colum	bit	MIN	2/	044	/			
	Sta Registr		JUN 2 5 200	- 1	2010	it to	all)								
			- JUI 6 J (U	1- 500	The state of the s	2000	Breeze.								

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. (. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 14 Month Day 2007 **Physician** -ULA june /Medical County of Death 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death Examiner Hospital 6. Sex thwest 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗙 F Months Days Hours Min Director maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director saltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?

1 □ Yes 2 No If Yes, Give Year or Dates: permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s any injury or other traumatic event, the Medical Examiner must Windsor Funeral Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) Black, White, etc. 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William linten 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dix-Neal Daughter 95tuart Mills Place Catensville MD
lace of Disposition (Name of Date 200. Location - City or 7 20a. Method of Disposition

1 Bunial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 06:21:07 Bultimere 22. Name and Address of Facility Vauyun C. Greene funcial Service 21. Signature of Funeral Service Licensee hoad handall stain MID 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PHEUMONIA /Medical Due to (or as a consequence of): **Examiner** ACQUIRED IMMUNO DEFICIENCY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transi and Due to (or as a consequence of): physician a P.O. Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1□ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 \sum Nursing Home 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ဥ 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of Injury Time of 28d. Describe how injury occurred Injury at Work? Certification: (Month, Day Year) To the Hospital or Attending 1 ☑ Natural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death

To the Funeral Director: completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29d. Date signed (Month, Day (fear) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

NORTHWEST HOSPITHLCENTEIL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Restrar's Signature

Kamabwa

31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of M	larylar	nd / Depa	artmen rtificat	it of H e of L	ealth a Death	and M	ental H	ygien Reg. N	- 0 0 1	2(	323
	Physic	ian	1. Decedent's Name (First, Middle, L	ast)							2. Date of D	Death		3. Tin	ne of Death
	/Medi		Mi chael	E.		Dusti	n				June	19	2007 Year	8	:16 p M
	Exami	ner	4a. Facility Name (If not institution, gi Holy Cross Hospital	ve street and number,	)		4b. City, Silve		Location of ing	f Death			c. County of Dea		·
г	Funeral			Sex 7. Aq 1√ΩM 2 ☐ F	ge (In yrs. 54	last birthday)	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of B (Month, L	irth Day, Yea	r) 9. Bi	rthplace (St	ate or Foreign
	Director		Usual Residence of Decedent			Yrs.					June 29			yland	
	yland		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Insid	le City Limits
	e Ma	ctor	Maryland Montgome	ery	Burt	tonsville	9							1√□	Yes 2□No
	or 28	Oire	10e. Street and Number				10f. Zip	Code				10g. C	itizen of What C	ountry?	
	ath w	ral	3736 Greencastle Road					2086	56			Unite	ed States	Americ	a
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene. Department of Heelih and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic avant. The Madical Exercities (sast ke notified at once.	by Funeral Director	11. Maritat Status  1 ☐ Never Married 2☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	)	l I	Vas Deced Yes, spec	v	spanic Orig n, Mexican, Specify:	in? (Spec Puerto F	cify Yes or N lican, etc.)	10-	14. Race - Am Black, Whi	te, etc.	n,
Ŏ	2 ho	ted	15. Decedent's E	ducation		16a. Deced	lent's Usua	I Occupa	tion			16h	Kind of Business	/Industry	
2	thin 7	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or:	5+)	16a. Deced (Give life. L	kind of wor OO NOT us	rk done di se retired)	uring most	of workin	g	100.	Time of Buoiness	viridustry	
2	filed w Hygier other th	Cor	12			Auto	Body W	Vorker				<i>I</i>	Auto Body		
and and	be fill bd ott	Be	17. Father's Name (First, Middle, Last	)					18. Mother	's Name	(First, Middle	e, Maide	n Sumame)		
Ž	should ind Men marke umatic	ı	Russell Dustin							hy Me					
<u>a</u>	d 2 si th an 17 is r		19a. Informant's Name/Relationship ( Laura Dustin / Wife	Type, Print)		19b. Mailin	g Address	(Street a	nd Number	or Rural	Route Numb	oer, City	or Town, State,		
ā,	tond Heelth tem 27 other tr		20a. Method of Disposition	-	20b. F	3736 Gr				Da					
Baitimore, Maryland 21215-0036	Pages nent of int: If It iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State		Place of Dispos emetery, crem		her place	!			20C. L	ocation - City or	lown, State	•
	permit. F Departme Importar any injure once.		21. Signature Juneral Service Lice		Met	ro Crema	tory Name and	d Address		/21/2			consville	MI	)
ñ	Ped Fig		Dhan s	has Ma						riec	k Funer urel, M	al Ho D 207	ome 207		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the deat									Approxi	nate
	Physician		Immediate Cause (Final disease or condition		ic Sho	ck								Onset a	Between nd Death
	/Medical Examiner		resulting in death)	Due to (or as											
	LAdillilei	<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of the consequence).												
	led isit	ol le	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
	akecu al-tra	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequ	uence of):									
00/9	certificate be executed rding physicien and use as the burial-transit	dicai		ď	,										
0	tificat ig phy as the	edic		d											
ŏ	endin r use	ician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome									23d. Date of deli	iverv	
	w requires that the death certific been signed by the attending p should be detached for use as i	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			Ctopic pre Other (spe						Month	Day	Year
	ine law requires that the steep says that the bas been signed by the page 2 should be detached.	Phys	9 Unknown												
ń	signe	۾	Part II. Other significant conditions of Bladder Cancer	ontributing to death bu	it not resu	ilting in the und	derlying cau	use given	in Part I.				use confribute to		
	been	Completed								_ '	10	Yes 2	®No 3∏Pro	obably 4	Unknown
ב ב	has has	E .									24a. Was auto	DSY	24b. Were au prior to d	topsy finding	s available cause of
ָ ס	n: Ir ficete r, pag										perfo	rmed? 2⊠ No	death?	2 No	
<b>5</b>	certi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ② No	Hospital:			-	1 0			Check only o				
5	ar this	- 4	27. Manner of Death	1 Lannpatier	28b. Time of			4 🗀 Nursi				6 ☐Other (Spec	eify)		
5	ath.	E	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	Year)	Injury	м	c. Injury a Work?	s 2∐No		28d. Describe how injury occurred				
2	or Automing Prysician: The lad affect death.  Director: After this certificete has in by the funeral director, page 2.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Ptace of Inju	ry - At hor	me, farm, stree	et, factory,				Location (	Street an	d Number or Ru	ral Route N	ımber
5	as Dia	Cer	T I TIONINGS	building, efc	. (Ѕреспу	,					City or Tox	vn, State	)		
1	vilhin 24 hours after death, within 24 hours after death, To the Funeral Director: After this certifica completely filled in by the funeral director, i	edic	29a. Certifier 1⊠ Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best o iner: On the basis of and manner stat		vledge, death of ion and/or inve	occurred at stigation, in	the time, n my opin	date and p ion, death (	occurred	d due to the at the time,	cause(s) date and	and manner as I place, and due	stated. to the cause	9(s)
F	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier	/	42	)	29c. l	License n	umber			29d. Dat	te signed (Month	, Day, Year	
	7		· Ma		. , ,			63343	3				6/20/2007	7	
10	)		30. Name and address of person who d				int)								
	Stat		Dr. Irina Ruban 15 31 Date filed (Month, Day, Year)	00 Forest G1	en Roa	ad_	Silver	r Spri	ng,	MD					
	Registra	~	JUN 2 5 200	37 Registra	Joigha	Jos.	de la								ì

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Russell Henry Demena Sr. 4:32 UNE 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Months Days Hours Min. 217 12 0207 85 Dec. 21, 1921 Maryland Usual Residence of Decedent 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 402 Kosoak Rd. 21220 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 X Yes 2 No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🔀 No Specify. 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Millwright Steel Mill 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

13718 Dixie Dr. Hagerstown ,

Holly Hill Mem. Garden's 6/25/2007

3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_

28c. Injury at Work?

1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

20b. Place of Disposition (Name of cemetery, crematory or other place)

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, splock, or heart failure. List only one cause on each line.

Mal nutrition

Due to (or as a consequence of)

23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

28a. Date of Injury (Month, Day Year)

Edythe Russell

Date

22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221

Maryland 21742

20c. Location - City or Town, State

23d. Date of delivery

Day

2 No 3 Probably 4 ☐ Unknown

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

Month

23e. Did tobacco use contribute to the cause of death?

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

1 ☐ Yes

28d. Describe how injury occurred

24a. Was an autopsy perform

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

Baltimore, Maryland

2 weeks

Year

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Physician /Medical Examiner

The law requires that the death certificate be executed

Examiner

Physician/Medical

Completed by

Be

ို

Certification:

Medical

**Physician** 

/Medical

10a. State

Director

Funeral

Completed by

Be

ပ

Roland Huges

20a. Method of Disposition

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions

23b. Was decedent pregnant

Anemia

25. Was case referred to nedical examiner?

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Sanjay Saxena M.D.

1 ☐ Yes

27. Manner of Death

1-Natural

2 Accident

3 ☐ Suicide

29a, Certifier

4 ☐ Homicide

(Check only

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

Deconditione

eu Kocytosi

5 ☐ Pending investigation

6 ☐ Could not be determined

it any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

19a. Informant's Name/Relationship (Type. Print)

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice

a

Phyllis Fauber (Daughter)

1 Burial 2 □ Cremation 3 □ Removal from State

**Examiner** 

**Funeral** 

Director

should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

and Mental Hygiene. Is marked other than

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau

and burial-trar the attending physician the as n signed by th. After this

Division or Vital Records, P.O. Box 68760.

Hospital or Attending Physician: within 24 hours after death To the Funeral Director:

filled in by

Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1138 Opal Ct. Hagerstown, Maryland

2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

State of Maryland / Department of Health and Mental Hygiene 20325 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Angela M. Duva11 Jumen 21, 2007 Year 10:25 pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Mariner Health of Glen Burnie Glen Burnie Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May 1 1, 1941 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1□M 2 F 216-38-4055 66 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location ir than "natural", or Items 23a or 28a-f show the Medical Examiner must by notified at 10d. Inside City Limits Completed by Funeral Director Maryland Howard Elkridge 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6055 Claire Drive 21075 USA 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Amarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Payroll Supervisor Bank permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Importent: if Itsm 27 is marked other ti any injury or other traumatic avent, the QDCS. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John F. Ireland Elizabeth ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mimi Duvall (Daughter-in-Law) 6055 Claire Dr., Elkridge, MD 21075 20b. Place of Disposition (Name of commetery, crematory or other place)
Baltimore Crematory
Loudon Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 ☐ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/27/07 Baltimore, MD 21. Signature of Funeral Service Linensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part1. Ent. (The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** DISTASE ALZHEIMERIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Que to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Nnknown Completed 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy performed?/ Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No this Director: After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \) an 24 house the Funeral Director 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier Medicai To the bast of the bast of the knowledge, death occurred at the time, deat and place, and due to the causers and manner as stated.

2 Medical Examiner. On the basts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Chack only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D17753 revery pressure 6/22/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 BALTIMORE 3721 PitE . Kising Astony, we 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar JUN 2 5 2007

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Year MARY AUSTIN DRIVER 9:02 A. June 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Timonium Baltimore If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Director 461-28-5061 83 16, Jan. 1924 Texas Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ner must be notified at 1 ☐ Yes 2 ▼No Director Maryland Baltimore Timonium 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 2300 Dulaney Valley Road 21093 Funeral U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11 Marital Status "natural", or item edical Examiner ι Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: ģ 3X Widowed 4 ☐ Divorced White Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Document Reproduction Petroleum 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be George Norman Austin Blanche Sessions 2 Stoner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ir portant: If Item 27 ary injury or other tr. John E. McCann 3 Trelawny Ct. Lutherville, Maryland 21093 (Per. Rep.) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Meadowridge Memorial Park 6-25-07 Elkridge, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Mitchell-Wiedefeld Funeral Home, 6500 York Road Baltimore, Maryland 23a. Bort. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, arock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ALZHEIMER'S DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

The law requires that the death certificate be executed certificate or Attending Physician: After this nours after death.

neral Director: Af

y filled in by the fur

MARY

Completed by

Be

2

Certification:

Medical

25. Was case referred to medical examiner?

29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

Year)

1 ☐ Yes 2X No

27. Manner of Death

1 X Natural

2 Accident 3 ☐ Suicide

4 ☐ Homicide

31. Date filed (Month)

29a. Certifier

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼ Unknown

28f. Location (Street and Number or Rural Route Number, City or Town, State)

6/21/07

autopsy performed? 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Year

Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 1 ∏Yes 2 ∏No

24a. Was an

The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital: 1 ☐ Inpatient

28a. Date of Injury (Month, Day Year)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

Registrar

32 Registrar's Signature

28b. Time of

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. ament items 4a, b, 26 per doc 969 7-9-07 vt.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Alvin Edwards 6 21 2007 7:50a /Medical 4a. Facility Name (If not institution, give street and number)

415 \*\*Milford Mills Rd.\*\* 4b. City Town, or Location Pikesville 4c. County of Death Examiner Baltimore Panda If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 M 2 ☐ F 5-1-1920 213-14-3820 Md. Director 87 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at show 1X Yes 2 No Baltimore Director · NA Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ns 23a or 2 must be n USA 21213 N. Linwood Ave. 1408 Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Examiner Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or iten ury or other traumatic event, the Medical Examiner 1 ☐ Never Married 2 ☐ Married No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes ¾☐ No Specify. Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Postal Service 12th grade Postal Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAMS ESTHER **ChARLES EDWARDS** ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1408 N. Linwood Ave., Baltimore, Md. 21213 Wife Alma Edwards 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) 6-28-07 Owings Mills, Md. Garrison Forest Vet. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East wan andi 1101 E. North Ave., Baltimore, Md. 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final IAV rebral VASCUL ACCIDENT **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 2 m Ellitus IABET caqueritatiny flet carumors, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No ed by the a 9 Unknown 9 Unknown been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? (es 2 No certificate 1 Yes the Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home - States dence 6 KOther (Specify) horse Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Inpatient funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation Natural Natural 1 Tyes 2 🗆 No 2 Accident after death the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2

State Registrar 29b. Signature and title of certifier.

31. Date filed (Month, Day, Year)

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JUN 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

m.D

5901

32. Registrar's Signature

29c. License number

D35102

29d. Date signed (Month, Day, Year)

2007

JUNE

North CHAYLES Street Baltimore Manylar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician GEORGIANNA** 17, KOHL FRIES 2007 3:00 P. June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 107-F **Versailles** Baltimore Circle Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 22, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 X F Yrs. 213-18-1891 86 1921 | Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. or them 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show aminer must be notified at 1 ☐ Yes 2 X No Director Maryland Baltimore Towson 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code the Medical Examiner must be 107**-**F Versailles Circle 21204 U.S.A. Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: þ Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 2 years Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William F. Kohl, Sr. Wilhelmina Ε. ျှ Lantz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21043 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau 2786 Westminster Road Ellicott City, Maryland Dr. Louis F. Fries, III (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Dulaney Valley Memorial Gardens 6-22-07 Timonium, Maryland 21. Signature of Funeral Service Licensee <sup>22</sup> Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, Maryland remaise 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pulmonary Immediate Cause (Final Physician hronic Year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760, as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mor 1 ☐ Yes 2/ ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Pres 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Necrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hospital or Attending Physician: within 24 hours a

0 State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of cortifier

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 130x lexander 32 Registrar's Signature 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2007 **Physician** 24, 5:45 A <sup>M</sup> June Walter William Farson, Jr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Eldercare Gardens Arbutus  ${ t Baltimore}$ If Under 1 Year | If Under 24 Hrs.
Months | Davs | Hours | Min. 8. Date of Birth (Month, Day, Year) Aug. 31,1915 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) 5. Social Security Number **Funeral** Months Maryland 1X7M 2□ F Aug. 91 212-03-8991 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 TYes 2 No Director Pasadena Anne Arundel Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ns 23a or must be r 21122 U.S.A. 1927 Orchard Point Road death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1Æ ]Yes 2 □ No If Yes, Give Year or Dates: W.W.II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 "natural", or Specify: White 3 Widowed 4 □ Divorced Completed r than "natur the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A Mechanic Railroad Department of Health and Mental Hygis Important; If item 27 is marked other i any Injury or other traumatic event, tt once.. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Farson, Sr. Sadie Connelly Walter ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Sappe-Hill (Daughter) 1927 Orchard Point Road Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 06/30/07 Meadowridge Mem. Pk. Elkridge Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune al Service Licensee Name and Address of Facility Cully-Polyniak Funeral Home, P.A. 7 East Patapsco Ave. Baltimore, Maryland 21225 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Approximate Interval Betwe Onset and De Immediate Cause (Final 3 **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an performed 2 100 25. Was cas examine Yes case referred to medical miner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 4 5515 Ted Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Mann of Death 28c. Injury at Work? After Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determine 4 ☐ Homicide

Director: within 24 hours a To the Funeral I

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

JUN 2

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29c. License number

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and addr

32 Registrar's Signature 31. Date filed (Mo. Year)

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			For State Registrar	State of Ivia	arylanu /	•	riment of H		-	giene Reg. No. :	A 14 M	00000	
			Decedent's Name (First, Middle,	Last)					2. Date of De Month	ath	2007	3. Time of Death	
	Physicia /Medic		William :	Elmer From	nm					21, Day	2007	7:34 A <sup>M</sup>	
	Examin		4a. Facility Name (If not institution,				_	Location of Death	1	4c. (	County of Death Baltim	iore	
-	Funeral		Gilchrist C  5. Social Security Number 6		e (In yrs. last l	birthday)_	Towso	If Under 24 Hrs.	8. Date of Bir	Birth 9 Birthplace (State or Foreign			
Ĭ	Director		213-28-7656  Usual Residence of Decedent	XXX M 2□F	77	Yrs.	Months Days	Hours Min.	oct. 1	6 <b>,</b> 19	30 Mar	yland	
	yland now at		10a. State 10b. County		10c. City, To	wn or Loca	ation				1	10d. Inside City Limits	
	e Mar la-fsh tiffed	ctor	MD Carr	:011		Fink	sburg					1 ☐ Yes XXNo	
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Coul		
	eath v	Funeral	1712 Deer Par		Ever in U.S.	13 W		048	necify Ves or No	- 1	U.S.A 4. Race - Americ		
36	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or items 23a or 28a-5 show atte event, the Medi- al Examiner must be notified at	by Fun	1 □ Never Married 2 □ Married  XX Widowed 4 □ Divorced	12. Was Decedent B Armed Forces? d 1 Yes XXI If Yes, Give Year or Dates:	No	- 1	Yes, specify Cuba □ Yes XX No	spanic Origin? (Spanic Mexican, Puerto Specify:	o Rican, etc.)		Black, White,		
Baltimore, Maryland 21215-0036	2 hou latura	ted	15. Decedent's	Education	16	Ba. Decede	ent's Usual Occupa	ation	deim m	16b. Kin	d of Business/In		
215	ithin 7 ne. nan "n Medi	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5	i+)			furing most of word )	king	Da. 1	h 1 ah aw	Chool	
21	lled will have the her the	ပ္ပ	17. Father's Name (First, Middle, La	3		Mac	hinist	18. Mother's Nam	ne (Eiret Middle		hlehem	Steel	
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7	should and Men s marke umatic	ဥ	19a. Informant's Name/Relationship		1:	9b. Mailing	Address (Street a	and Number or Ru		<del>-</del> _	Town, State, Zip	o Code)	
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ore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other		20a. Method of Disposition 1 ☐ Burial X Cremation 3	Removal from State	20b. Place ceme	of Disposi etery, crem	ition (Name of atory or other place	e)	Date	20c. Loc	cation - City or To	own, State	
Ĕ	Pages ment of I		4 ☐ Donation 5 ☐ Other (Spe	ecity)	Metro	o Cre	matory		5/22/0			ore, MD	
3ail	permit. Departn Importa any Inju	IJ	21. Signature of Juneral Service Li	censee								apel P.A. 1s,MD 2111	
	HD = # 0		23a Part1 Enter the disease, or or	omplications that caused	I the death. D						igs mii.	Approximate	
	Dhysisian	8 94	23a. Part1. Enter the disease, or conshock, or heart failure. List on Immediate Cause (Final	DIAR	522 W	o not eme	and mode of dyna	g, scorr as cardiae	or respiratory a	irosi,	1	Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as		ce of):	we pout	74				yens	
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	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a consequenc	of).							
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687	tificate g phys as the	edical		d									
	= 0,0		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		ath a□	Estania prognana			2	3d. Date of deliv	ery	
	ne deat the atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown			Ectopic pregnancy Other (specify)	-			Month	Day Year	
<u>G</u>	uires that the de signed by the a d be detached for		Part II. Other significant condition	s contributing to death b	ut not resulting	g in the und	derlying cause give	en in Part I.	23e. Did	tobacco us	se contribute to t	the cause of death?	
Vital Records, P.O. Box	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	Completed by	Vuscular dise	<i>₩</i>		-			1 🗆	Yes 2	No 3 Prol	bably 4 □Unknown	
eco	has bee	plet							24a. Was	psv	24b. Were auto	opsy findings available ompletion of cause of	
<u>~</u>	: The	Con							perfo 1□ Yes	ormed? 2 X No	death? 1 ☐ Yes		
Ĭ.	certifi rector	Be	25. Was case referred to medical examiner?	Hospital:			2 DOA Othe	26. Place of Dea			·		
ō	Phys	2	1 ☐ Yes 2 No 27. Manner of D ath	28a. Date of Inju	ent 2 ER/0	Outpatient b. Time of	3 □ DOA   28c. Injury Work	4 LI Nursing H	lome 5 Resi		Other (Special	W MUSPICE	
on	nding tth. r: Afte e fune	tion	1 Natural 5 Pending 2 Accident investiga	(Month, Day	y Year)	Injury		k? Yes 2 ☐ No					
Division or	To the Hospital or Attending Physician: The I within 24 burns after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could no 4 Homicide determin		ury - At home, c. (Specify)	farm, stre	et, factory, office			Street and wn, State)		al Route Number,	
	Hospital Puncia Funeral C		29a, Certifier Certifying	Physician: To the best	of mv knowled	dge, death	occurred at the tin	ne. date and place	e, and due to the	cause(s)	and manner as	stated.	
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical		xaminer: On the basis of and manner sta	f examination								
	To the within 2	Σ	29b. Signature and title of certifier	_			29c. License				e signed (Month,		
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Registrar

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		-	for State Registrer	State	of Marylan		artmeni rtificate					giene Reg. No.	00	7	20	332
	Discount of		1. Decedent's Name (First, Middle	, Last)						2	2. Date of De. Month	ath Day	Ye	ar	3. Time o	
	Physicia /Medic		Ann Fackett								June 4				6:58	PM M
	Examin	er	4a. Facility Name (If not institution,		ımber)		4b. City,			of Death			ounty of C altin			
			7825 Wise Ave:	nue 6. Sex	7. Age (In yrs.	last birthday)	If Under		If Under		B. Date of Bir	h		Birthpla	ce (State	or Foreign
	Funeral Director		213-09-5678	1 ☐ M 2 🂢 F	87		Months	Days	Hours	Min.	(Month, Da ov 30,	1919	M	countr ary]		
pd	Name of the last		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	neation							10	d. Inside (	City Limits
lanyla	e hov	'n	MD Balti	more	100.00	Balti										s 2√2 No
the N	28a-1	rect	10e. Street and Number			Darer	10f. Zip	Code				10g. Citize	n of Wha	t Counti	ry?	
with	3a or	Funeral Director	7825 Wise Aven	ue					21222	2			US	SA		
death	me 2	ner	11. Marital Status	12. Was Dec	edent Ever in U.	.S. 13.	Was Deced	ent of Hi	spanic Or	igin? (Spec	ify Yes or No ican, etc.)	- 14	Race - A	America White, e		
after	or leading and and and and and and and and and and	y Fu	1 Never Married 2 Marri	ed 1 ☐ Yes If Yes, G	2∭∑ No ive		1 🗆 Yes					1	pecify:	whit	:e	
hours	ture!	ed by	3  ☐ Widowed 4 ☐ Divorced  15. Decedent	Year or I	Dates:	16a Dece	dent's Usua	I Occupa	tion		1-	16b. Kind	of Busin	ess/Indu	ustry	1 .
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y id	and Mental Hygiene. Is marked other then "neture!", or iteme 23a or 28a-f show reumatic event, its Medical Examinat must be nutified at	၉	Joseph Mark G					(2)			Hoduli		Cta	to Zin (	Codel	
<b>2</b> 73	モトコ		19a. Informant's Name/Relations Andrew Fackett								Route Numb					
1 and	Health tem 27 other tr		20a. Method of Disposition	J1/50II	20b. F	Place of Dispe	osition (Nar	ne of	- :	rrace	Ealti	20c. Loca	ition - Cit	y or Tov	vn, State	
5 8	ent of it: If i		1 ☐ Burial 2 ☐ Cremation 4 ☑ Donation 5 ☐ Other (S)		n State	cemetery, cre	matory or o	trier placi	*/ 							
Dallillor Dermit. Peges	Department of Heali Important: If item 2 eny injury or other <u>2005</u> .		21. Signature of Funeral Service Ronald S		Director		2. Name ar	d Addres	s of Facil	ity Roo	rd 655	T.T D	01+4	m 0 10 1	C+2	oot.
2 0	8 5 8	. 1	23a. Part1. Enter the disease, or	// ///	2 11 //	100				•			<u> </u>			
			shock, ar neart failure. List	complications that only one cause on	each line.			e of dying	g, such as	s cardiac or	respiratory a	rrest,			Approxima Interval Be Onset and	etween d Death
	ysician		Immediate Cause (Final disease or condition resulting in death)	_ a ( C	olon c	ance	1.							1	200	7
	Medical caminer		rooding in dod.i.,	Due to	o (or as a consec	juence of):										
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ecords, F.C. BOX 66/60, law requires that the death certificate be executed	physicien and s the burial-transit	edlcal		d												
OX O	attending ph	/Me	IF FEMALE:		utcome of pregn							23	d. Date o	of delive	ry	
death D	d for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 \(\sumsymbol{\text{Yes}}\) 2 \(\overline{\text{Z}}\) No	4∐Pre	birth 2 Feta gnant at time of c		⊒Ectopic p ⊒ Other (sp						Month		Day	Year
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es the	signed by the a lid be detached f	ል	Part II. Other significant condition	ons contributing to	death but not res	sulting in the	underlying o	ause give	en in Part	1.		tobacco us Yes 2 🗷	1			T death? ]Unknown
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sicie	s certi	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpatie	ent 3 D	Oth			(Check only ne 5 Res		———— ☐Other	(Specify	·)	
		n: T	27. Manner of Death	28a. Dat	e of Injury onth, Day Year)	28b. Time	of :	28c. Injur	at	2	8d. Describe	how injury	occurred			
VISION . Attending	or: Af he fur	satic	1 Patural 5 Pendir 2 Accident investi	gation			М	1 🗆	Yes 2							
or Att	⊕ <u>−</u> _	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 288. Fla	ce of Injury - At h Iding, etc. (Speci	nome, farm, s ify)	treet, factor	y, office		2	Bf. Location City or To	(Street and wn, State)	Number	or Rurai	Houte Nu	umber,
Hospitel	eret E		29a. Certifier 1 Certifyir	ng Physicien: To t	he hest of my kn	owledge dea	th occurred	at the tin	ne date a	and place, a	nd due to the	cause(s) a	ind manr	er as st	ated.	
9 H	Eun Fun letely	Medical	(Check only 2 Medical one)	Exeminer: On the	basis of examin anner stated.	ation and/or i	nvestigation	i, in my o	pinion, de	ath occurre	ed at the time	, date and p	lace, and	d due to	the cause	∋(s)
To the	within 24 hours af To the Funerel D completely filled in	Me	29b. Signature and title of entitie	1/1.	)		29	c. Licens	e number	1 -		29d. Date	signed (	Month, I	Эа <b>у,</b> Year	)
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			30. Name and address of person	1 /	use of death (Ite	m 23a) (Type	, Print)	11	2-	R.	. Ot	M	0:	11	22:	
		ate	31. Date filed (Month, Day, Year)	191 32	. <del>Rö</del> gistrar's Sign	I J O L O	W/Co	1 10	IN	1)0		110	/	// (	M	/
	Regist		JUN 2	5 2007	Delegan	B. A.	conse	9								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-04572 State of Maryland / Department of Health and Mental Hygiene Kevin Wayne Franks 1. For State Certificate of Death Reg. No Registrar 2. Date of Death I. Decedent's Name (First, Middle,Last) Physician/ Month Day June 15, 2007 0839 hrs Medical Examiner Kevin Wayne Franks c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Rockville 11815 Old Drovers Way 8. Date of Birth (MM/DD/YYYY)

May 31. 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Foreign Min Months Days Hours Director Country Maryland 1972 1 X M 2 35 Yrs 219-76-8540 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 X No Maryland Rockville Montgomery event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or items 23a or United States 11815 Old Drovers Way Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? White, etc. Never Married 2 X Married 1 X Yes Specify: White Yes 2 X No specify: Divorced If Yes. Give Year Widowed "natural", à 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) 72 ten 27 is marked other than imore, MD 21215-0036 Pages I and 2 should be filed within 73 nent of Health and Mental Hygiene. Finance Company Salesman/Webmaster 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Trinia Sue Farmer Rollin W. Franks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 19556 Fisher Avenue, Poolesville, MD 20837 Melissa J. Harris / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, rtment of He rtant: If ite y or other ti crematory or other place) Burial 2 X Cremation 3 Removal from State Montgomery Crematorium, Inc June 24, 2007 Bethesda, Maryland Donation 5 Other Specify: 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 West Montgomery Avenue, Bethesda, Maryland 20580 21. Sign ture of Funeral Service Licensee Rockville, Inc., 3 Bethesda, Maryland M01473 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a Part I. Enter the disea Physician Between Onset and failure. List only one cause on each line Medical Death Cocaine intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical X UNPENDED X AMENDED perFH, G868, 6/25/07 TT // 23a,27,28a-f, perME,g869. attending physician or use as the burial 7/10/07 Box 68760, 23d. Date of delivery IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? Month Ectopic pregnancy Day Year Live birth Fetal death 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. þ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy certificate has b rector, page 2 sh death? performed? 2 No Yes 2 No ✓ Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Residence 6 🗸 Other: Scene Nursing Home 5 Inpatient 2 ER/Outpatient 3 this 1 V Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) After 28b. Time of Injury 27. Manner of Death Medical Certification: 1 Natural 1 Yes 2 X No Pending unk Fnd 6/15/2007 Fnd 8:30 am 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 3

To the Hospital or Attending Physician: Division of Vital To the Funeral Director: within 24 hours after death

28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be orTown, State) 11815 Old Drovers Way Rockville, MD determined (Specify) Found: residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signaturb June 16, 2007 O.C.M.E.

30. Name and address of person who completed ause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201 Susan Hogan MD Assistant-Medical Examiner

31. Date filed (Mo Day, Year, Registrar

32 Registrar's Signature ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Stephen J. Furlong June 19, 2007 2:50A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1503 Defoe Street Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 X M 2 □ F Director 63 330-36-8613 February 1, 1944 Illinois Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at Director 1 XYes 2 □ No Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1503 Defoe Street 20850 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 1968–1972 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Divorced White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer Security 5+ U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ James Furlong Margaret McFadden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Elizabeth J. Furlong/ Wife 1503 Defoe Street Rockville, Maryland 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State June 4 Donation 5 Other (Specify) Heaven Cemetery 2007 25, Silver Spring, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Juneral Service Licensee M00335 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Liver Failure disease or condition resulting in death) Days /Medical Due to (or as a consequence of): Examiner Metastatic Esophageal Cancer Weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical the IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal dea 4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1∐ Yes 2 No 2 X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2X No Certification: To 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours aft le Funeral DI eletely filled in 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0064115 June 20, 2007

Registrar

State

9707 Medical Center Drive, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32 Registrar's Signature

Kelly Woods Mercer,

JUN 2 5

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 18 per in 9869 /-16-0/ vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Marie R. Goebel 24 2007 5:10 a June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Stella Maris Timonium Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, July 21, 1 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🛛 F Yrs. 1914 92 216-05-2393 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Md . Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 2828 Aspen Hill Rd. USA Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural', or Items 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White ò 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the M Office Worker Clerical 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Gollinger Kollinger Frank Roycroft ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Carol Schneider/ Daughter 2828 Aspen Hill Rd . Baltimore, Md. 21234 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Most Holy Redeemer Cem.6-28-07 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 21. Signature of Fundamental Licen 4 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician CONGESTIVE HEART FAILURE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 🛣 No 3 ☐Ectopic pregnancy Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE after death.

I Director: After this c 1 Yes 2 No ပ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 6/25/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) h 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 DR. TARIQ MAHMOOD 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

JUN 2 5 2007

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 36 AM 200 06 2 0 /Medical 4c. County of Death 4a. Facility Name (If no institution, give street and number) 4b. City, Town, or Location of Death Examiner Battimore Medical lenter Bayview Johns Hopkins
5. Social Security Number 8. Date of Birth (Month, Day, Year)
July 25, 1959 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) unk If Under 1 **Funeral** Months Days Hours 1**X** M 2□ F 47 216-78-0248 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location with the Maryland 10a, State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at ty∑Yes 2 □ No Baltimore Director MD 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 21205 USA 2724 Ashland Avenue Funeral death v 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? unk. 11 Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after the Health and Mental Hygiene. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 □ No unk 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: black Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced 16h Kind of Business/Industry unk Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4940 Eastern Avenue Baltimore, MD 21224 Johns Hopkins Bayview Hospital 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remoyal from State 4 ☐ Donation 5 ☐ Other (Specify) In State 21. Signature of Funeral Service Licensee Ronald S. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Director Baltimore, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Chuse (Final Acute Myo cardial **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 □Ectopic pregnancy 1 Live birth Month Year Day Por in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify). ☐Yes 2☐No P.O. detached the 9□Unknown 9 ☐ Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed t should be deta Records, 2 1 ☐ Yes 2 ☐ No 🏋 Probably 4 ☐ Unknown Completed 24a, Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 perform 2 No 1⊟ Yes Division or Vital Physician: ector, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: No. 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this o completely filled in by the funeral director. ပ္ Date of Injury (Month, Day 28d. Describe how injury occurred 28b. Time of Injury at 27. Manner of Death Certification: njury Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide ō To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier E5-001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

4940

32. Registrar's Signature

DuffANE

JUN 2

ROBERT

31. Date filed (Month, Day, Year)

EASTERN AVE, BALTIMORE, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year a M Jackie June 21, 2007 Ray Harris 9:51 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Laurel Regional Hospital Prince Georges Laurel 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

June 10, 1937 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Hours 1**™**M 2□F Months Min. Maryland Yrs **Director** 70 219-26-5023 Usual Residence of Decedent 10c. City, Town or Location 10h. County 10d. Inside City Limits 1 ☐XYes 2 ☐ No Director Maryland Anne Arundal Laure 1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1B. Rose Street United States America Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2**½** If Yes, Give Year or Dates: 1 Never Married 2 Married 2**₹** No 1 ☐ Yes 2 ☐ No Specify. þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Engineer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Lewis Bobbie Mae Chandler ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3194 Cardinal Dr. West Minister Maryland 21157 Robert Harris / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Meadowridge Mem. Park June 25, 2007 Elkridge, Maryland 21. Signature - Funeral Service Licensee 22. Name and Address of Facility Fleck Funeral Home 7601 sandy Spring Rd Laurel our 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 10 years Immediate Cause (Final disease or condition resulting in death) **Physician** Arteriosclerotic Cardiovascular Heart Disease /Medical Due to (or as a consequence of): Hypertension 10 years Sequentially list conditions Due to (bries a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examir 10 years Hyperlipidemia Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 X\0 ၉ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification:

Examiner death certificate be executed burial-transi Box 68760, physiciar the as 1 attending use for P.0. the signed by t d be detach Division or Vital Records, requires 2 should aw has The page certificate Physician: rector, this funeral dir al or Attending P After il Director; /

show notified at

28a-1

item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be

d 2 should be filed within the and Mental Hygiene.
7 is marked other than "

permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic ev

72 hours after

Maryland 21215-0036

Baltimore,

1 Natural 2 Accident 5 Pending investigation

(Month, Day Year) 6 Could not be

MOSE

28c. Injury at Work? 1 Tyes 2 🗌 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

21

29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

3□ Suicide

4 Homicide

29c. License number

29d. Date signed (Month, Day, Year)

addre ss of pe

determined

impleted cause of death (Item 23a) (Type, Print 4012

State Registrar 31. Date filed (Month, Day, Year) IIIN 2 5 200 Registrar's Signature

within 24 hours a

To the Funeral I

completely filled the Hospital

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10

Medical

			For State Registrar	State of	Marylan		artment of H <i>rtificate of</i>	Health and M <i>Death</i>		ene 007	20336
			Decedent's Name (First, Middle, La	ast)					2. Date of Death Month	Day Year	3. Time of Death
П	Physicia /Medic		James G	len	H	lolman			June 20	2007	8:30 a <sup>M</sup>
	Examin		4a. Facility Name (If not institution, gi		nber)			r Location of Death		4c. County of Dea	
			2124 Fernglen 5. Social Security Number 6.		7. Age (In yrs.	last hirthday	Catonsv		8. Date of Birth	Baltimon	tholace (State or Foreign
	Funeral Director			1⊠M 2□F	80	Yrs.	Months Days	Hours Min.	Sept. 3	, 1926 Kar	thplace (State or Foreign ountry) 1S3S
	ס		Usuel Residence of Decedent		10.00	· · · ·					10d. Inside City Limits
	arylar ehow	_	10a. State 10b. County			y, Town or L					1 ☐ Yes 2 🛣 No
	he M	Director	Maryland Baltimo:	re	Ca	tonsv	10f. Zip Code		10	g. Citizen of What C	ountry?
	Sa or		2124 Fernglen W	ay			212	28		USA	•
	death	Funeral	11. Marital Status	12. Was Dece Armed For	ident Ever in U	.S. 13.	Was Decedent of I	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
စ္တ	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other than "natural", or items 23s or 28s-f show other treumstic event, the Modical Examinat must be inclified at		1 ☐ Never Married 2 ⚠ Married	1 X Yes If Yes, Giv	2 No	тт	1 ☐ Yes 21 No	Specify:		Specify: Wh	
Ö	hours tural',	ed by	3 Widowed 4 Divorced  15. Decedent's 8	Year or Da	ates: WW		dent's Usual Occup	pation	1	6b. Kind of Business	/Industry
5	n na Medic	plet	(Specify only highest g	rade completed) College (1	-4or 5+)	(Give	kind of work done DO NOT use retire	during most of work	ing		
212	giene giene er tha	Completed	Elementary/Secondary (0-12)	5+	-401 547	Elec	ctrical E			Westingho	ouse
D	d oth	Be	17. Father's Name (First, Middle, Las Glenn	James		Holm	nan	18. Mother's Name		izabeth	Champion
Maryland 21215-0036	hould d Men marke matic	ဥ	19a. Informant's Name/Relationship							City or Town, State,	
<u>≅</u>	ith an treum		Betty L. Holman							e, MD 2122	
ē,	s 1 ar		20a. Method of Disposition		in it	Place of Disp	osition (Name of			0c. Location - City o	
Ē	Page nent o nnt: If ury or		1 ☐ Burial 2X Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			Toudo	a Domle	6/22		altimore,	
Baltimore,	permit. Pages 1 Department of H Important: If ite ony injury or ot		21. Signature of Funeral Service Lice	ensee		2				Funeral lore, MD 21	
	20 = 0		23a. Part1. Enter the disease, or co	molications that c	aused the deat	h Do not er					Approximate
			shock, or heart failure. List on	y one cause on e	ach line.	۷,		4			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to	or as a consec	a Ti C	Esc	phagea	1 (0)	ncer	1 month
	Examiner		Convertially list acaditions	b.							
	D #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (	or as a consec	quence of):					
λo.	and and II-trans	Examiner	that initiated events resulting in death) Last	c. Due to (	or as a consec	uence of):					
8760,	icate be executed physicien and s the burial-transit	dlcal E		d							
9	tificat ng phy as th	an I	IS SELVALE.					-			
Вох	The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		ointh 2 Fete	el death 3	□Ectopic pregnand	<b>Э</b>		23d. Date of do Month	elivery Day Year
0	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregn 9□ Unkno	nant at time of o own	death 5	Other (specify) _				
<u>α</u>	that the by detail	y Ph	Part II. Other significant conditions	contributing to de	eath but not res	sulting in the	underlying cause g	ven in Part I.	23e. Did tob	acco use contribute	to the cause of death?
rds	w requires been sign should be	ed by							1 □ Ye	s 2000 3□F	Probably 4 DUnknown
000	aw requast been 2 should	Completed							24a. Was ar	prior to	autopsy findings available completion of cause of
ž		Com							perform 1 Yes 2	ied? death? Deno 1 ☐ Ye	s 2 No
/ita	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			10	than	th (Check only one		
to	Phys rthis ral dir	5	1 Yes 2 No	28a. Date	Inpatient 2 C	28b. Time	ant 3 DOA	4   Nursing H	ome 5 Reside 28d. Describe ho	nce 6 Other (Sp w injury occurred	ecify)
o	nding Ith. : Afte	atlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigat		th, Day Year)	Injury		ork? ]Yes 2 □No			
Division of Vital Records,	er dea	Certification;	3 Suicide 6 Could not	ad 286. Place	of Injury · At h	ome, farm, s	treet, factory, office		28f. Location (St. City or Town	reet and Number or I , State)	Rural Route Number,
ō	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Diractor: After this certific completely filled in by the funeral director,										
	Hosp 24 hou Fune Fune stely fi	Medical		aminer: On the b						luse(s) and manner a ate and place, and di	
	To the vithin To the Somple	Me	29b. Signature and title of certifier	4 i				ise number	25	9d. Date signed (Mon	nth, Day, Year)
)	. >= 0		Sharm H	2. Ine (	Coma	L M	D	38762		June.	21,2007
	641		30. Name and address of person who 54// Old Fr	io completed caus	se of death (Ite	m 23a) (Typo	Print) Sha	Callings	Cornach	21229	
	. J ,	ate			1.0:			DE IT, LOW	1 1.0.	ociad!	
	Regist		JUN 2 5	2007	Silve A	M. A	racke				

page 2 s within 24 hours after death

To the Funeral Director:
completely filled in by the

	shock, or heart failure. List only	one cause on each line.	. 3,	,	Interval E	
	Immediate Cause (Final disease or condition resulting in death)	. Sepsis			Onset an	d Death
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  Due to (or as a consequence of):  C			30	years
ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 1€ pronths? 1 ☐ Yes 2 € No 9 ☐ Unknown		pic pregnancy er (specify)	23	3d. Date of delivery  Month Day	Year
ted by Ph	Part II. Other significant conditions of	contributing to death but not resulting in the underly	ing cause given in Part I.		se contribute to the cause o	Unknown
Complei				24a. Was an autopsy performed? 1□ Yes 2X No	24b. Were autopsy finding prior to completion o death? 1 ☐ Yes 2 ☐ No	gs available f cause of
Be	25. Was case referred to medical examiner?		26. Place of Death	(Check only one)		
0	1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3		ne 5□Residence 6	□Other (Specify)	
ation:	27. Manner of Death  Natural 5 Pending Accident Investigation		Work?	8d. Describe how injury	occurred	
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		actory, office 2	8f. Location (Street and City or Town, State)	Number or Rural Route N	umber,
Medical (	29a. Certifier (Check only one)	nysician: To the best of my knowledge, death occuminer: On the basis of examination and/or investig and manner stated.	urred at the time, date and place, a lation, in my opinion, death occurre	and due to the cause(s) and at the time, date and	and manner as stated. place, and due to the caus	e(s)
ž	29b. Signature and title of dertifier		29c. License number	29d. Date	signed (Month, Day, Year,	)
	V. Cast	W MD	AT243894	6 Tu	ne 21.26	07

0427 AM

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 □Yes XXNo

Maryland

U.S.A.

Black, White, etc.

Specify: White

State Registrar

To the Hospital or Attending

erson who completed cause of death (Item 23a) (Type, Print)

gistrar's Signa

(Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day Physician aro June 2007 05:45 A /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Hospita Baltimore Johns N/A Hopkins If Under 24 Hrs. Age (In yrs. last birthday)
63 Yrs. If Under 1 Year 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 💢 F Hours 484-50-4210 December 20, 1943 Iowa Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he accessed. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Pennsylvania Lancaster 1 ☐ Yes 2 ☑ No Lancaster Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1037 Signal Hill Lane 17601 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. Aq. Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kenneth Mundt Shirley Goodwin ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Eugene E. Honert 1037 Signal Hill Lane Lancaster Pennsylvania 17601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 6/29/07 Conestoga Mem. Park 4 Donation 5 Dother (Specify) Lancaster Pennsylvania 22 Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Asystole minutes disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner troly 2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Squamous attending physician and for use as the burial-transit The law requires that the death certificate be executed ears resulting in death) Last P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) 9☐ Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, δ 1 ☐ Yes 2 No 3 Probably 4 Nnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 200 completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 \subseteq Nursing Home 1 Yes 2**N**0 1 npatient 2 ER/Outpatient 3 DOA ဥ 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Director: After To the Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours after To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 000 M.D. pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who con

State Registrar Serrano

31. Date filed (Month, Day, Year)

600

N 32. Registrar's Signature

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 6:30 am **Physician** June 25, Sophia A Idzi 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 2514 Londonderry Rd. Timonium Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🗓 F 89 Yrs. Jan. 11, 1918 N.J. 217-05-7866 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28e-t ahow the Medical Exertinar outst be notified at Timonium 1 ☐ Yes 2 No Baltimore Director Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 2514 Londonderry Rd. 21093 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 11 Marital Status filed within 72 hours after 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 25 No Specify: Specify: White þ 3 ₩idowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 yrs. Housewife Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: It Item 27 is marked oth any injury or other traumatic avant ODES. Be Alexander Kruszewski Helen Jablonski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2514 Londonderry Rd. Timonium Md. 21093 Dolores Hicks daughter 20b. Place of Disposition (Name of cometery, crematory or other place)
Sacred Heart of Mary June 29 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Dundalk 2007 4 □ Donation 5 □ Other (Specify) <sup>22. Name and Address of Facility</sup>
Connelly Funeral Home Of Dundalk 21. Signature of Juneral S 7110 Sollers Point Rd. 21222 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mould **Physician** Lent /Medical Due to (or as a consequence of): Examiner VON-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of): Examiner signed by the ettending physicien and i be detached for use as the burial-transit or Attanding Physician: The law requires that the death certificate be executed Se A5 -5 Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital within 24 hours after death.

To tha Funarel Director: After this certific completely filled in by the funeral director. To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Medical Certification: 1 Alatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier June 25, 2007 who completed cause of death (Item 23a) (Type, Print) 10 M.D. 3512 Rtz 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 25 2007 Registrar

			For State Registrar	State o	f Maryland		artment <i>tificate</i>			nd Me		giene Reg. No.		203	
N. 3	Physici	an	Decedent's Name (First, Middle     Decedent's Name (First, Middle)								Date of Dea Month	Day	Year	3. Time	
- 5	/Medic	al	Stella Hutchison  4a. Facility Name (If not institution				4b. City, T	over or l	ocation of		June	7	007 unty of Death	7:20	)a '''
-	Examin	er	Fairhaven	i, give street and nu	moery		-	esvi		Dogur			roll		
-	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1	Year	f Under 2		Date of Birt	h Voarl	9. Birth	place (State	or Foreign
40	Director		220-12-8850	1 □ M 2 □ XF	93	Yrs.	Months	Days	Hours	Min.	ec 27	1913	MD	intry)	
	pu ≱ ∷		Usual Residence of Decedent  10a. State 10b. County		10c, City	, Town or Lo	cation							10d. Inside (	City Limits
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	h with the . 23a or 28a	Funeral Director	10e. Street and Number 7200 Third Ave	nue			10f. Zip 0					10g. Citizer USA	n of What Cou	intry?	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie markad other than "natural", or iteme 23e or 28e-f show eny injury or other traumatic event, it a Medical Exactinat must be notified at once.	by Funer	11. Marital Status  1 □ Never Married 2 □ Marr  3 অ Widowed 4 □ Divorced	Armed F	2 XNo		Was Decede f Yes, specif		anic Origi Mexican, Specify:	in? (Speci Puerto Ric	fy Yes or No can, etc.)		Race - Amer Black, White pecify: whi	, etc.	
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Mary	and 2 shoil alth and h		19a. tnformant's Name/Relations Mr. Anderson Jo	hip <i>(Typ</i> e, <i>Print)</i> ohnston (	stepson)	19b. Mailir 521 I	ng Address ( Riverv	Street an	d Number Dr.,	or Rural F Heat	Route Numbe hsvill	er, City or To .e, VA	own, State, Z 22473	p Code)	
more	Pages 1 announce of the control of t		20a. Method of Disposition 1 ☐ Burial 2 [X]Cremation 4 ☐ Donation 5 ☐ Other (S)		Channe	lace of Dispo emetery, crer Count	natory or off	er place)	on 6-	Dat 22 <b>–</b> 0			tion - City or 1 ville,		
Balti	permit. Departn Importe ony inju		21. Signature of Funeral Service  Paige Houge		ent						ht Fur 11e, M		Home & 84	Chape	e1
760, 2	Physician /Medical Examiner prize princip prize	icai Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfusiate Cause (Disease or injury that initiated events resulting in death) Last	a	stroint (or as a consequ (or as a consequ (or as a consequ	uence of): uence of):	al b	ilea	ed					Interval B Onset and	d Death
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	9		30. Name and address of person	TAN	720	00 T	nirc	1 A	VQ.	Ç	5yke	2501	e 20	10 3	21784
	Sta Registi		31. Date filed (Month, Day, Year)  JUN 2	19	Registrar's Signa	y. A	out!								

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	Examin	192	4a. Facility Name (If not institution, give street and number)  4	b. City, Town, or Location of Death	4c. (	County of Death	
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	ath wi		7200 Third Avenue	21784		USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 1 N Never Married 2 □ Married 1 □ Yes 2 1 No	us Decedent of Hispanic Origin? (Specify Ness, specify Cuban, Mexican, Puerto Rican  Yes 2 No Specify:	n, etc.)	4. Race - America Black, White, e Specify: Wh	etc.
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yland	ould be fil Mental H arked ott atic even	To Be	17. Father's Name (First, Middle, Last)  John H. Klohr	18. Mother's Name (Firs Laura E	mmart		
, Mar	is 1 and 2 shi of Health and Item 27 Is m other traum	7 8	Edward S. Klohr 1203 Do	Address (Street and Number or Rural Rou Oves Cove Road Balt	imore, MI	21286	
Baltimore,	Pages 1 nent of Hi ant: If Iter ary or oth		4 Donation 5 Other (Specify)  Mt. Olive	tory or other place) Cemetery 6/23/20	07 Rand	ation - City or Tov	, MD
Balt	permit. Departr Importa any inje		21. Signature of Funeral Service Licensee Had P. C	Name and Address of Facility Ight Funeral Home & D. Box 195 Sykesvil	Chapel, 1e, MD 21	P.A. 784 (410	-795-1400)
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	the mode of dying, such as cardiac or res	piratory arrest,		Approximate Interval Between Onset and Death 2 day S
8760, M	sate be executed ohysician and the burial-transit	ical Examiner	Sequentially list conditions, if any hadring to minerialle cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b.  Due to (area a consequence of):  c.  Due to (or as a consequence of):				
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	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier  (Check only   2   Medical Examiner: On the basis of examination and/or investigations)	occurred at the time, date and place, and d	due to the cause(s)		
	To the H within 24 To the F complete	Medical	one) and manner stated.  29b. Signature and Mile of certifier	29c. License number		signed (Month, I	.,
			Dece Mo	D52035		Tune	19 2007
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri	int) me Mp 211	157		
	Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri School And Color and Col	r V			

State Registrar

DHMH 17 Rev 1/2001

HOSPITAL OF BALTIMORE 2401 W. Belvedele AVE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 04 2007 DOY /Medical 4b. City, Town, or Location of Death County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE If Under 24 Hrs. 4030,TAL MORE 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Min 1 **M**M 2 □ F Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 es 2 No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ☐ Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 20No Specify: <u>^</u> While 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) IN-FANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname s 1 and 2 should be file f Health and Mental H tem 27 Is marked oth Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) PARENTS permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tra KRAINES eremy COURT BALTIMORE 20a. Method of Disposition

1 Burial 2 □ Cremation 3 □ Removal from State Date 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Tuneral Service Licensee 200 Approximate interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory part heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner ed by the attending physician and detached for use as the burial-transit Division or Vital Records. P.O. Box 68760. IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? /es 2 No 1□ Yes al or Attending Physician: after death. 25. Was case referred to medical Be Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA မ 28a. Date of Injury (Month, Day Year) 27. Man er of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural Injury 5 Pending investigation 2 No 1 ☐ Yes 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3□ Suicide determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral DI 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death SiNAI of BALTIMOLE 2401 W. Delves HOSPITAL AIMUR ChAUdhe State

DHMH 17 Rev 1/2001

Registrar

Registrar

State

31. Date filed (M

DHMH 17 Rev 1/2001

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 10:10 A M Leo Leasure Jr. 21, June 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore 1117 Orems Rd. Middle River If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct. 11, 1929 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1**X** M 2 □ F 77 Maryland Director 220 30 8315 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural"; or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be marked. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director Maryland Baltimore Middle River 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1117 Orems Rd. 21220 USA Completed by Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Korean Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 If Yes, Give Korean Year or Dates: Conflict 1 ☐ Yes 2X No 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Steel Mill Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Felker Leo Leasure Sr. ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9702 Conmar Rd. Baltimore, Maryland 21220 Ronald Leasure (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/25/2007 Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Signature of Funeral Service Li 0 Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocordia 1 OVROY /Medical Due to ( as a consequence of): Examiner (ovovor-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed and as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month filled in by the funeral director, page 2 should be detached for 5 Other (specify) ☐Yes 2☐No the 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Be Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No OM 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2□ No 1 🗆 Yes 2X No ob ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☒ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To s after death. al Director: After th 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Hospital 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

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31. Date filed (Month, Day, Year) JUN 2 5 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certified



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29c. License number

29d. Date signed (Month, Day, Year)

Certificate of Death Reg. No. -1. Deceptent's Name (First, Middle, Last) 2. Date of Death Month **Physician** IDLEME eann ETTE 06 16, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M 2 F Days Yrs June 16, 1920 Director 87 158-12-7172 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Funeral Director MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7101 Bayfront Drive 21403 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 3 office manager permit. Pages 1 and 2 should be filed. Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Mallette Kelley Minnie Isabel Hanners 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William LaViolette/spouse 7101 Bayfront Drive Annapolis, MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ② Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 23a. Part. Enter the disease, or complications that caused the death. shock or heart failure. List only one cause on each line. Baltimore, MĎ 21201 To not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9□ Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No Completed 24a. Was an autopsy page 1□ Yes funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2No Hospital: Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined completely filled in by 4 ☐ Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifie 29c. License number

Name and address of person completed cause of death (Item 23a) (Type, Print)

11CHMA 31. Date filed (Month, Day,

4451) EXENSE HIGHWAY 32 Registrar's Signature

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JUN 2

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

9. Birthplace (State or Foreign Country) New Jersey

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

1 ☐ Yes 2 No

unk

082 i M

Year

07

Race - American Indian, Black, White, etc.

Specify: white

23d. Date of delivery

Day

3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician  $\mathbf{A}^\mathsf{M}$ Judson 21, Roger Loebenstein June 2007 9:30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, August 1, Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Days 218-52-7508 54 Washington, D.C. **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Director Maryland Montgomery Bethesda 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5714 Aberdeen Road 20814 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerio Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Completed by Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) 5+ Physical Scientist Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ William V. Loebenstein Sara A. Clements 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Loebenstein / Wife 5714 Aberdeen Road, Bethesda, Maryland 20814 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) June 23 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc 4 Donation 5 ☐ Other (Specify) 2007 Bethesda, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Vagelette Bang wit M01305 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a convequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner aw The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) 4:30 c Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No in by the funeral director, age 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an has autopsy this certificate 2027 No 1∐ Yes I or Attending Physician: after death. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dispatient ို 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Director: After 5 ☐ Pending investigation 1/ENatural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital or within 24 hours aft To the Funeral DI completely filled in 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) 30. Name a Rohatgi, M.D. 8600 Old Georgetown Road, Bethesda, Maryland 20814 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

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Division or Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year)

JUN 2 5 2007

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. ... 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** moore UNE 20 200 /Medical 4a. Facility Name (If not institution, dive street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NA t050, tal IMORR 5 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** -2760 1 №M 2 F Months -60-,05,195 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "nature" any injury or other traumatic excessions. 10a. State 10b. County 10c. City, Town or Location 10d. Inside Aty Limits 1 Yes 2 No md. Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2122 0 Funeral 12. Was Decedent Eyer in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 Notes: 1 ☐ Never Married 2 ☑ Married 2**\_**No 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) materia Elementary/Secondary (0-12) College (1-4or 5+) management NIA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be moore ULLER harles ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Backmore, md. 54 701 Dana moore 20b. Place of Disposition (Name of cemetery, crematory or officer place) 20a. Method of Disposition 1 Sourial 2 □ Cremation 3 □ Removal from State 6-23-0 4 ☐ Donation 5 Other (Specify) 21. Signature uneral Service Liganore 22. Name and Address of Facility FredHILTON Pas 23a. Part Errer me disease, or complications that caused the death. Do not enter the clode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ARDIOPULMONARY Hour disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-trar Vital Records, P.O. Box 68760, № Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 month Month Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ ₩0 24a. Was an cate has autopsy perform certificate Hospital or Attending Physician; 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2∐ No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Division or this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 D Natural 5 ☐ Pending investigation ours after death.

neral Director: A
filled in by the ft 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) se of death (Item 23a) (Type, Print) dress of person who completed ca Mc GANN, DO anton 900 Registrar's Signature 31. Date filed (Month, Day, Year) State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month JUNE 21, Day 2007 Mary J. Morris **Physician** 5:15a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Long View Nursing Home Manchester Carrol1 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🙀 F 228-54-7481 78 APR 15. 1929 Director Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10h County 28a-f show "natural", or items 23a or 28a-f shov idical Examiner must be notified at 1 ☐ Yes 2 N No Director Maryland Carro11 Manchester 10f. Zip Code 10g Citizen of What Country? 10e. Street and Number with 3128 Main St. Apt. B 21102 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must any Injury or other traumatic event, the Medical Examiner must onee. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □XNo Specify Specify: White 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker/cook 8 Domestic/restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fred Orick Deame Spurlock ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Martha J. Mingee/daughter P.O. Box 129, 3128 Main St. Apt.B Manchester. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Sykesville, MD All County Cremation Service 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Haight Funeral Home & Chapel, P.A. P.O. Box 195 Sykesville, MD 21784 (410-795-1400) mudom Emm Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) obstructive Phlmonny disense chronic **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by DUSMAMONI 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an performed? Yes 2 X No 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the death occurred at the time, date and place, and due to the cause(s) and manner as stated.
| Comparison of the death occurred at the time, date and place, and due to the cause(s) an 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Creansylita MD

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Hestminstelz, MD 21157.

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month JUNE 11:00 AM Joseph Francis McAdam III 23. 2007 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 08/31/32 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 1 ☑ M 2 ☐ F 213-30-9184 74 Illinois Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6806 N. Charles Street 21204 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 No Specify: White Specify: 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Civil Engineer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Francis McAdam, Jr. Irene Heinick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret M. Ondov/Daughter 11715 Janney Court, Clarksville, MD 21029 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Serv. Corp. 06/27/07 Towson, MD 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Juneral Service Licensee 1050 York Rd., Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEVERE CHRONIC OBSTRUCTIVE PULMONARY Due to (or as a consequence of) DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of CORONARY ARTERY DISEASE Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably XXUnknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? 1 Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 1 X Inpatient 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

ms 23a or 3

th and Mental Hygiene. 7 Is marked other than "natural", or items ? traumatic event, the Medical Examiner mu

of Health

permit. Pages 1
Department of H
Important: If Itel
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Pages 1 and 2 should be filed within 72 hours after

Saltimore, Maryland 21215-0036

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Funeral

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Examiner Physician/Medical þ Completed Be r

burial-tran the as attending properties for use as signed by the a page 2 s director, this

The law requires that the death certificate be executed certificate or Attending Physician: s after death.

I Director: After this din by the funeral d

Division or Vital Records, P.O. Box 68760,

within 24 hours aft To the Funeral Di completely filled in To the Hospital Medical flet1 State Registrar

Certification:

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

27. Manner of Death

5 ☐ Pending investigation 6 ☐ Could not be

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier -clia

28a. Date of Injury (Month, Day Year)

29c. License number D 41410

1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 23 200

28f. Location (Street and Number or Rural Route Number, City or Town, State)

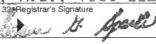
28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MEHTA, JOGINDER P. M. D. . 7601 OSLER DRIVE. TOWSON. MARYLAND 21204

31. Date filed (Month, Day, Year)

JUN 25



28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

		Please	Type or Print in E State of Marylan				_	_	
		1 - For State Registrar	State of Marylan		rtificate of			Reg. No.	20355
Dhusia	ian.	Decedent's Name (First, Middle, La	st)				2. Date of De	The Color of B	3. Time of Death
Physic /Medi			Ronald May		I		June 2	3, 2007	5:25 A M
Exami	ner	4a. Facility Name (If not institution, give	,			r Location of Death	1	4c. County of De	
Funeral	_	Stella Maris Hosp 5. Social Security Number 6.5	Sex 7. Age (In yrs.	last birthday)	Timoni If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	Baltim	rthplace (State or Foreign Country)
Director	·		I M 2 □ F	71 Yrs.	Months Days	Hours Min.	March	28,1936 Mai	
land ow tt		Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Lo	ocation				10d. Inside City Limits
Mary a-f she ified a	tor	Maryland Harford	Bela	ir					1 ☐ Yes 2 ☐ No
ith the or 28; se not	Direc	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	Country?
s 23a nust t	Funeral Director	707 S. Fountain (		C 113		1015	nasifu Vas ar Na	USA 14. Race - Am	nerican Indian
fter de ritem ilner r	Fun	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No		Was Decedent of H If Yes, specify Cub	an, Mexican, Puer	o Rican, etc.)	Black, Wh	ite, etc.
III (A. I. I. I. 3-UU30 be filed within 72 hours after death with the Maryland that Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify: Wh	ite
"natu	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	ation during most of wor	rking	16b. Kind of Busines	s/Industry
withir iene. than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		nine Oper			Electr	ic
e filed al Hyg other	BeC	17. Father's Name (First, Middle, Las	")				ne (First, Middle,	Maiden Surname)	
alylal should b ind Ments marked umatic e	To	NIcholas	May				garet	Foos	
VICIONA 12 shc h and 7 Is m		19a. Informant's Name/Relationship Geraldine T. May	Type. Print) (Wife)		-			er, City or Town, State, lair, Mary	, ,
t and Health tem 27		20a. Method of Disposition	20b. F	lace of Dispo	osition (Name of	1	Date	20c. Location - City of	
altification of partment of portant: If its portant: If its y Injury or of ce.		1 X Burial 2 ☐ Cremation 3 ☐ 4 Donation 5 ☐ Other (Speci	JHemoval from State		matory or other pla Cemetery		27,2007	Baltimore	County, Md
mit. rmit. porta y Inja		21. Six a ure of Euperal Service Lice	nsee) - l	22	2. Name and Addre	ess of Facility Bi	cuzdzins	ki Funeral	Home PA
0 88 E 8 8		7-13-6	2					sex Maryla	
		23a Part Lenter the disease, or con shock, or heart failure. List only					or respiratory a	rrest,	Approximate Interval Between Onset and Death
Physician /Medical	ı	Imme tiat Cause (Final diseas condition resulting in death)	a. End Stage Par		n's Disea	ase			
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be tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence of):					
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The law requires that the death certificate are has been signed by the attending physicage 2 should be detached for use as the	Physician/Medic	IF FEMALE:							
BOX eath cer attendin for use	cian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3	☐Ectopic pregnanc☐Other (specify) _	у		23d. Date of d Month	elivery Day Year
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has b	Completed						24a. Was autor perfo		autopsy findings available completion of cause of
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ysicla ysicla lis cer direct	To Be	examiner? 1 ☐ Yes 2 █ No	Hospital: 1   Inpatient 2	ER/Outpatier	nt 3 DOA Oth				pecify) HOSPICE
nding Pt ath. r: After the e funeral		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo		28d. Describe I	how injury occurred	
Vittend death. ctor: /	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	e 28e Place of injury - At he	ome, farm, sti		Yes 2 □ No	28f. Location (	Street and Number or I	Rural Route Number.
al or A	Certification:	4 ☐ Hornicide determined	building, etc. (Specif	y)	, , , , , , , , , , , , , , , , , , , ,		City or Tox		
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Medical (		hysician: To the best of my knominer: On the basis of examina and manner stated.						
To the within To the	Me	29b. Signature and title of certifier	)		29c. Licens			29d. Date signed (Mo	nth, Day, Year)
ø.			1		0	4372	5	6/25	5/07
12		30. Name and address of person who					10		
	ate	DR. TARIQ MAHMOO  31. Date filed (Month, Day, Year)	D 2300 DULANE	Y VALL	EY RD. 7	CIMONIUM,	MD 2109	93	
Regist		UIN 2 5 2	32. Degistrar's Signa	# B	3CALED				

JUN 2 5 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1- For State Amend #26, perMD, g868, 6/25/07 TT Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4.20 AM 2007 06 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Albo Home Easton 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Days Hours 218-18-945 1 ☐ M 2 F Yrs MARYLAND Director Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 27 is marked other than "natural", or items 23e or 28a-f show treumatic event, the Madical Examinar must be muilibed at 1 Yes X No Director Graysonville MDQueen Annes 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 1000 Oyster Cove Drive 21638 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor Manufacturing Industry 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be nd Mental ed bluods 2 David Graham Annie McIntyre 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health item 27 I 1000 Oyster Cove Drive, Graysonville, MD 21638 Mr. Patrick M. McGowan (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ₽ Desial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. Loudon Park Cemetery 06/20/2007 Baltimore, Maryland ■ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fignature of Funeral Service Licensee Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atturage Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the as use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year ō 4 Pregnant at time of death 5 Other (specify) detached o 9 Unknown ت 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 page 2 No 1 Yes of Vital director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: Hospital: 1 ☐ Yes 2 No 4 □ Nursing Home → Nursing Home 6 ★ Other (Specify) Hospice 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) Certification; 27. Manner of Death After Division or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral D Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person LANE, MHBUBA

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 2

5

2. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month 10:30P <sup>M</sup> 19, Francis Ε. Murray June 2007 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Ellicott City Nursing & Rehab. Ellicott City Howard 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1X M 2□ F 218-10-4371 86 22, 1920 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2€ No MD Baltimore Woodstock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10304 Davis Avenue 21163 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 12⊈ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Management Supplies Verizon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Μ. Murray Edith Fuhrman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan M. Mathena Daughter 10304 Davis Ave., Woodstock, MD 21163 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/20/07 Carroll Cremation Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Ste her Eline Funeral Home Reisterstown, MD 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MENOSCIENO ue to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred

The law requires that the death certificate be executed and the burial-trai Division or Vital Records, P.O. Box 68760, attending physician for use as the buria ed by the a cate has been signed by page 2 should be detact certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p

Physician

/Medical

Examiner

Examiner Physician/Medical 2 Completed Be Certification: To

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hyghene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be none.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

death with the Maryland

1 Natural

2 Accident

3 ☐ Suicide

29a, Certifier

Medical

4 Homicide

5 Pending investigation

6 Could not be determined

NI)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

29b. Signature and title of certifier

29c. License number 00063534 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 main ST Reister town ND 21136

randona 100 31. Date filed (Month, Day, Year)

JUN 2

32. Resistrar's Signature

State

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Carrie F. Miller June 22, 2007 8:32am /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Genesis Elder Care Hammonds Lane Brooklyn, MD Anne Arundel If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) July 5, 19 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1□ M 3/5/F 212-26-1447 78 MD Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or itams 23a or 28a-1 shov other treumatic event, the Medical Examinat must be rediffed at MD MYes 2 No N/A Baltimore City Director 10g. Citizen of What Country? 10e Street and Number 10f. Zio Code 1822 South Charles Street 21230 United States 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11. Marital Status Black, White, etc. uit. Pages 1 and 2 should be tilled within 72 hours atter-ortment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or ital njury or other treumatic event, the Medical Examina 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married white Maryland 21215-0036 1 ☐ Yes 2XXXIII Specify: 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 9 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Robert E. Bloss, Sr. Emma Mae Saunders 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert E. Bloss, Jr. / Son 1822 South Charles Street, Baltimore MD 21230 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition or other place) Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 6/25/2007 Baltimore Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 permit.
Departr
Importa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** End Stage Renal Disease 6 months /Medical Due to (or as a consequence of): **Examiner** Atherosclerotic Cardiovascular Disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit Due to (or as a consequence of): Physician/Medical as IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 DEctopic pregnancy Month ρ in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f Ö 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 1 Yes 2 No 3 Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an page 2 s autopsy performed? 2**∏** № 1 Tes 2**X** No Division of Vital funeral director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🔀 No Medical Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Atter 5 Pending investigation 1 X Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 | Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D29807 June 23, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 106 1406 S Crain HWY, Glen Burnie MD 21061 Carlos D. Zigel, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Dean	Lee	Oberholtzer,	Jr.
Dean	Lee	Obelholizel,	01.

Commonwealth   Comm		1- For State Registrar	_	Certific	ate of	Death		R	eg. No.		
Deen Lee Uberholtzer, Jr.  ## Foundary    Deen Lee Uberholtzer, Jr.	Physician/		e,Last)		2. Date of Dea	th					
So Control of Control	Medical Examiner						1540 hrs				
217-55-7221   X   X   X   X   X   X   X   X   X		· · · · · · · · · · · · · · · · · · ·	n, give street and numbe	er)	41			th	1		
28		5. Social Security Number	6. Sex 7. A	Age (In yrs. last bi	rthday)	<del></del>			th(MM/DD/YYYY		
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21. Signature of Funeral Service Luddinger William G. Dau  22. Name and Address of Facility Ruck Towson Funeral Home, Inc.  1050 Orac Red. Towson MD 21204  239. Part Letter the disease, or complications that caused the death. Do not enter the mode of dyes, such as carriaged or respiratory arrest, shock, or heart failure. Lat only one cause or one cause or each line.  249. Part Letter the disease, or complications that caused the death. Do not enter the mode of dyes, such as carriaged or respiratory arrest, shock, or heart failure. Lat only one cause or each line.  259. Part Letter the disease, or complications that caused the death. Do not enter the mode of dyes, such as carriaged or respiratory arrest, shock, or heart failure. Lat only one cause or each line.  259. Part Letter the disease, or complications that caused the death. Do not enter the mode of dyes, such as carriaged or respiratory arrest, shock, or heart failure. Lat only one cause or condition resulting in death)  259. Securiting is condition.  259. Was case deduct pregnant in the part of death or conditions as consequence of):  250. Was case deduct pregnant in the part of death or conditions as consequence of):  250. Was case referred to medical examiner?  250. Was case referred to medical examiner?  250. Was case referred to medical examiner?  250. Was case referred to medical examiner?  250. Was case referred to medical examiner?  250. Was case referred to medical examiner?  250. Was case referred to medical examiner?  250. Death (These 2 No.)  250. Was case referred to medical examiner?  250. Was case referred to medical examiner?  250. Death (These 2 No.)  250. Was case referred to medical examiner?  250. Death (These 2 No.)  250. Was case referred to medical examiner?  250. Death (These 2 No.)  250. Was case referred to medical examiner?  250. Death (These 2 No.)  250. Was case referred to medical examiner.  250. Death (These 2 No.)  250. Was case referred to medical examiner.  250. Death (These 2 No.)  250. Was case referred to medical exami	MOr Pages ent of ent I			Hillt	op Se	rv Corp	06	5/25/07	Towso	n, MD	
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Methodoco   Period   Color   Period   Color   Period			on each line.						est, shock, or hea	Between Onset	
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30. Name and address of person who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201  State Registrar  31. Date filed (Month, Day, Year)  22. Registrar's Signature	E > F 0 M	29b. Signature and little of pertific	er /								
Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201  State Registrar  Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201  A. Registrar's Signature  Registrar  Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201	6					0.0.0	I. C.		June 22, 2	007	
Registrar JUN 2.5 2007 Steen & Jones	OCME					Penn Street,	Baltimore,	MD 21201			
				trar's Signature	front.	,					

07-04698 James D. Owings

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Death		R	leg. No.	JUI EUJO					
Physic Medical Exam	ian/	1. Decedent's Name (First, Midd	e,Last)  O. Owings					2. Date of Dea Month	Day Year	3. Time of Death		
,	IIIIe	4a. Facility Name (If not institution	_	er)	- 4	b. City, Town, or L	ocation of De	June 19, 1	2007 4c. County of D	2019 hrs		
R 1		5520 Mt. Gilead Road		01)		Reisterstown		aur	Baltimore County			
Funera		5. Social Security Number	6. Sex 7.	Age (In yrs. last	birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of Bi	of Birth(MM/DD/YYYY) 9. Birthplace (State or			
Directo		213-90-3478	1 <b>XX</b> M 2 F	44	Yrs.	Months Days	Hours	Min.	9, 1962	oreignMaryland Country)		
s design and a second		Usual Residence of Decedent						pvOv•	7, 1902			
w any		10a. State 10b. County		10c. City, To	wn or Location	on				10d. Inside City Limits		
/land yland -f show once.	후	MD Balt	imore	I	Reist	erstown	1		1 Yes $XX$ No			
UIUUU ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 5520 Mt. Gi	100 d Dd			10f. Zip Code		1	10g. Citizen of What Country?			
death with the Maryland riems 23a or 28a-f she must be notified at once	무	11. Marital Status		-15 : 110	140 101	211				S.A.		
ath w items	Funeral	1XXNever Married 2 Ma	12. Was Decederarried Armed Force	es?	13. Was	Decedent of Hisp s, specify Cuban,	oanic Origin? Mexican, Pue	(Specify Yes or No erto Rican, etc.)	14. Race - A White, et	merican Indian, Black, tc.		
fter de l'', or		3 Widowed 4 Div	orced If Yes, Give Year	XX No	1	Yes XX No	specify:		Specify:	White		
2 hours a "natura	d by	15. Decedent's Education (Spec	or Dates: cify only highest grade of	completed) 16	a. Decedent	s Usual Occupation	on (Give kind		16b. Kind of Busine			
	Completed	Elementary/Secondary (0-12)	College (1-4 o	or 5+)		st of working life. [		retired)	31.7			
15-0036 filed within 72 Hygiene.	I E	12			H	andymar				1 Labor		
21215-0036  suld be filed within 72 hou Mental Hygiene. marked other than "nat event, the Medical Exa	Be C	17. Father's Name (First, Middle, James C1 a	ayton Owi	nas		18		me (First, Middle,				
	O.B	19a. Informant's Name/Relationsl	nip (Type, Print )		19b. Mailing	Address (Street			A. Lawle			
nore, MD 21 ages 1 and 2 should nt of Health and Me nt: If item 27 is man other traumatic ev	1	Margaret A. O	wings / Mo	ther	5520 N	4t. Gil∈	ead Rd	.; Reis	terstown	, MD 21136		
re, l 1 and f Heah f item er tra		20a. Method of Disposition	0 - 1	20b. Plac	e of Disposit	ion (Name of ceme		Date	20c. Location - Cit			
Baltimore, permit Pages I an Department of Hea Important: If iten		1XXBurial 2 Cremation  4 Donation 5 Other Sp			yt. G	ilead Cemeter	,,	6/23/07	Reister	rstown, MD		
Baltimo permit Page Department Important: injury or ott		21. Signature of uneral Service	Licensos	1 5114	22. Na	me and Address	of Facility <b>E</b> C	khardt	Funeral	Chapel P.A.		
		Turband.	mun		11.16	005 Reis	sterst	own Rd.	Owings N	Mills,MD2111		
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause	complications that cause on each line.	ed the death. Do	not enter the	mode of dying, s	uch as cardia	c or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and		
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	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cor	nsequence of):								
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Records, P.O. Box 68760, The law requires that the death certificate be exacted has been signed by the attending physician eage 2 should be detached for use as the burial	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outo	ome of pregnanc	СУ				23d. Date of deli			
30x 687 death certific e attending 1	cian	past 12 months?	I Live birth	at time of death	[]	I death 3	Ectopic preg	gnancy	Month	Day Year		
Box e death c the atten ed for us	Physicia	1 Yes 2 No 9 Unki	own 9 Unknown		5 Othe	er (Specify)			Ì	1		
P.O. es that the gned by t		Part II. Other significant condition	ons contributing to dea	ath but not result	ting in the un	derlying cause giv	en in Part I.	23e. Did to	bacco use contribute	e to the cause of death?		
S, P uires th signe d be d	d by							1 Yes	2 No 3 F	Probably 4 V Unknown		
of Vital Records, P.C in Physician: The law requires that ther this certificate has been signed the retail director, page 2 should be detail	Completed							24a. Was a autop		e autopsy findings available to completion of cause of		
Reco	E							perfor	med? death	h?		
L	യ	25. Was case referred to medical				26.Place of	f Death (Ched			765 2 100		
Vit	To B	examiner? 1 ✓ Yes 2 No			Outpatient	3 DOA	ther Nur	sing Home 5	Residence 6 🗸 0	ther: Scene		
~ ਵਾੜਾ ਨਵੀ	Ë	27. Manner of Death  1 Natural 5 Death	28a. Date of In (Month, Day	njury 28b ,Year)	. Time of Inju			1 .	now injury occurred			
Siol Attent death ector:	cati	5 Pendi	igation FNO 0/19		d 8:04	DIII	s 2 X No	unk				
Division tal or Attendins after death. al Director: △	É	3 Suicide 6 XCould	not be		farm, street,	factory, office buil	Iding, etc.	28f. Location (S	tate) 5520 Mit	Rural Route Number, City		
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification:	4 Homicide determined (Specify) house  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death oc				d at the time of the		JJZU 611	ead Ka. Keis	sterstown, MD		
thin 24 the F	dica	Check only	iner: On the basis of ex	amination and/or	r investigation	d at the time, date n, in my opinion, d	and place, a leath occurre	nd due to the cause d at the time, date a	e(s) and manner as s and place, and due to	stated. the cause(s)		
To To COI	and manner stated.  29b. Signature and title of certifier  29c.					29c. License r			29d. Date signed (			
	O.C.M.E.						June 20, 2007					
T	30. Name and address of person who completed cause of death (Item 23a)											
/ 1	Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, M					e, MD 212	01					
	State 31. Date filed (Month, Day, Year) 3. Legistrar's Signature Registrar 31. Date filed (Month, Day, Year) 3. Legistrar's Signature					6.11						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** ATTERSON 2007 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Square BAITIMORE FRANKLIN Hospila ose Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 F Months Hours Min. 60 Director 218-44-4082 March 3, 1947 Md. Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 77 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Md. Baltimore Dundalk 1 ☐ Yes 2 1 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or : 813 Jay Dee Ave. Funeral 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Itimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify: þ Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Rehab Center 9 yrs. Nursing Asst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be fi Department of Health and Mental I-Important: If item 27 is marked of any Injury or other traumatic ever once. Bydler Patterson Lucille Kaun 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Hudson 813 Jaydee Ave. Dundalk Md. 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 25 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Baltimore Bayview Crematory 4 □ Donation 5 □ Other (Specify) 2007 22. Name and Address of Facility Connelly Funeral Home of Dundalk 7110 Sollers Point Rd. 21222 21. Signature of Juneral Service Licenses Part /. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** - 4NG CANCER, NON SMALL disease or condition resulting in death) /Medical Due to (a) as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical attending pl IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ COPD Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an certificate has birector, page 2 s autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident (Month, Day Year) 5 ☐ Pending Injury M 1 ∏Yes 2 ∏No investigation within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3107 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLIN SQUARE DR. BAITIMORE, Md 21237
32 Registrar's Signature lia SSON 31. Date filed (Month D State Registrar

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State of Maryland / Department of Health and Mental Hygiene 20362 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Рм 23 4:00 Ava M. Porta June 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore Keswick Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Min. | March 23, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 1 ☐ M 2 💢 F 96 Yrs. MD Director 218-03-4019 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f ehow 1 ☐ Yes 2√ No Directo Baltimore Parkton 10g. Citizen of Whal Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23s or any hiury or other traumatic event, the Medical Exemples mant be a 21120 USA 2 Caribou Court Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, While, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White δ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Be Catherine Winder Ezekiel Mills ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 Caribou Court, Parkton, MD 21120 John E. Porta/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition New Cathedral Importent: If It any Injury or o once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 27, 07 Baltimore, MD 21. Signature of Funeral Service Lic 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd.. Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FAILUY CON 125TIVE neavt <sup>o</sup>nysician resulting in death) /Medical Due to (or all a consequence of): Examiner 110 ETF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a sunsequence of) Examine Hospitel or Attending Physician: The law requires that the death certificate be executed as the burial-transit Division of Vital Records, P.O. Box 68760, attending physician and resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea:
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy for Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ briknown 24a. Was an autopsy performed 24b. Were aulopsy findings available prior to completion of cause of death? 2 -NO 1 Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Cther: 4- Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 2 ER/OutpatienI 3 DOA Certification; To 1 Inpatient within 24 hours after death.

To the Funerel Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical ş 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 3510 June 24 mmo 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHArles Street North m-1). 7901 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2 5 2007

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2007 Month Year Jose A. Potenza June 22, РМ 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice <u>Timonium</u> Baltimore Hours Min. 8. Date of Birth (Month, Day, Year) Jan. 15, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, Days Months Yrs 214-50-5062 76 Argentina Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Baltimore Towson 10e. Street and Number 10f. Zip Code 10g Citizen of What Country 909 Shelley Road 21286 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married <sup>Specify:</sup>Argentine 1 X Yes 2 □ No Specify: 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Pressman Jos. A. Bank Clothiers 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Roque Potenza Maria Damiano 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dora M. Potenza wife 909 Shelley Road; Towson, MD 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 2 ☑ Cremation 1 ☐ Burial 3 □ Removal from State Hilltop Service Corp. 6/26/07 Towson, MD 5 ☐ Other (Specify) 4 □ Donation 22. Name and Address of Facility 21. Signature 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death se contribute to the cause of death? No 3 Probably 4 Unknown

**Physician** /Medical Examiner

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Department of H
Important: If iter
any Injury or oth

**Physician** 

/Medical

Examiner

10a. State

MD

**Funeral** 

Director

"natural", or Items 23a or 28a-f show edical Examiner must be notified at

Director

Funeral

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Completed

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Examiner

Physician/Medical

Completed by

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Certification:

Medical

State

death with the Maryland

Baltimore, Maryland 21215-0036

physician and s the burial-trans Division or Vital Records, P.O. Box 68760,

been signed by the should be detached

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1 □ Yes 2 □ No 9 □ Unknown	9□Unknown	
t II. Other significant conditions	s contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco us 1 ☐ Yes 2 ☐
		24a. Was an autopsy performed?

	24a. Was an autopsy performed? 1 ☐ Yes 🏋 No
26. Place of Dea	th (Check only one)
Other: 4 Nursing H	ome 5 ☐ Residence 6 <b>X</b> Other (Specify) <b>HOSPICE</b>
Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred
fice	28f. Location (Street and Number or Rural Route Number, City or Town, State)

27. Manner of Death 1 Natural 2 Accident	5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes	2	28d. Describe	how injury occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, fact		28f. Location (Street and Number or Rural Ro City or Town, State)		
							e cause(s) and manner as stated a, date and place, and due to the
201 01 1 1	ille of or alling			On License numb	nor		OOd Date siened (Ments Dave

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

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29b. Signature	ano	uue	OI	cerm	iei
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		1			

25. Was case referred to medical examiner?

1 ☐ Yes 2 No

lace, and due to the cause(s) Date signed (Month, Day, Year)

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RU. TARIQ MAHMOOD

31. Date filed (Month

32. Aegistrar's Signature

State Registrar

DHMH 17 Rev 1/2001

JUN 8 9 2001

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H.S. 7575 GKEENWAY CENTUR DILIVE SUITE113 GKEEN 32LT HD

				State of Maryland / Department of Health and M  1- State Registrer  Certificate of Death		ene 0 7	20355
		Physici /Medic		1. Decedent's Name (First, Middle, Last)  Roy Allen Przywara	2. Date of Death Month	Day Year 200	3. Time of Death 7 4:45 P M
4		Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  FRANKLIN SQUARE HOSPITAL  5. Social Security Number  6. Sec 4A (e. )  7. Age (In yfs. last birthday)  If Under 1 Year If Under 24 Hrs.	8. Date of Birth	4c. County of Deat	
		Funeral Director		217 62 3350 10 Months Days Hours Min.  Usual Residence of Decedent	Oct.1,19	956 Mar	yland
		laryland show	'n	10a. State 10b. County 10c. City, Town or Location  Maryland Baltimore Essex			10d. Inside City Limits 1 ☐ Yes 2X No
		with the N a or 28a-f be notifi	Direct	10e. Street and Number 106 Margaret Avenue 107 Zip Code 21221	10	g. Citizen of What Co USA	untry?
4	"	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Itams 23a or 28a-f show int. The Medical Examinar must be notified at	Be Completed by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specific Specific Cuban, Mexican, Puerto In Charles)  14. Never Married 2 Married 1	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	e, etc.
WARA	5-0036	2 hours a atural', or cal Ezam	ted by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:  15 Decedent's Education 16a, Decedent's Usual Occupation	1	Specify: Whi	
$\rightarrow$	21218	filed within 7 Hygiene. other than "n	ompie	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Ship Builder	i	Ship Yard	
PRZ	/land	d be antal kad o	To Be (	17. Father's Name (First, Middle, Last)  Leonard Przywara  18. Mother's Name Alice Wi		aiden Sumame)	
<u>&gt;</u>	Mary	and 2 shoulealth and Mealth and Mealth and Meart is marlearteanati		19a. Informant's Name/Relationship (Type, Print)  Alice A. Przywara (Mother)  19b. Mailing Address (Street and Number or Rural 56 Left Wing Dr. Baltin			
X	altimore,	of H of H f Itan		20a. Method of Disposition  1 XBurial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Sacred Heart Of Jesus 6/23/		oc. Location - City or Baltimore,	
	Baltir	permit. Pag Department Important: I any injury o		21. Sign and Address of Eacility Bruzdziński Funeral 1407 Old Eastern Av	l Home P.	. A .	
		Physician /Medical Examiner  pnuial-transit	Examiner	23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac constructions are conditional content of the mode of dying and a cardiac construction of the mode of dying, such as cardiac construction of the mode of dying and construction of the mod	or respiratory arre	st,	Approximate Interval Between Onset and Death
	P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funaral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical E	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of del Month	very Day Year
		uires that n signed b ild be det≀	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to	
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	Division of Vital Records,	il or Attending Fafter death. Director: After	Certification;	2 Accident investigation M 1 Yes 2 No	28f. Location (Stre City or Town,	eet and Number or Ru State)	iral Route Number,
	1	To the Hospital or Att. within 24 hours after de To the Funeral Direct completely filled in by ti	Medical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and the control of the			
		To the within To the compl	Me	29b. Signature and title of certifier 29c. License number		d. Date signed (Monti	
	,	6T		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		lune 21,	2007
		∠ Sta	te	31. Date filed (Month, Day, Year)  32. Figistrar's Signatury  14. L. C. S. 2007	102123	6	
		Registr		WWW & 5 2007			

DHMH 17 Rev 1/2001

			1- For State of Maryland / De C	partment of Health and Mertificate of Death	lental Hygie		20366
	Physici		1. Decedent's Name (First, Middle, Last)  LEWIS E PARSONS	5	2. Date of Death Month	Day Year	3. Time of Death  08: +0 4 <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	th
			ECI	Westover	8. Date of Birth	Somerse	
	Funeral Director		5. Social Security Number  6. Sex  7. Age (In yrs. last birthdo	Months Days Hours Min.	(Month) Day,	(ear) 9. Bill	thplace (State or Foreign buntry)
	f show	ō	10a. State	Location			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	a or 28a-	Director	10e. Street and Number Revells Neck Road	10f. Zip Code 2181		g. Citizen of What Co USA	-
2	, or items 23	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. 1 Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (Spiff Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: b1	te, etc.
0500-61717	uses a rate a should be filled within 72 hours are used that in the way and to freath and Mantal Higher. If item 27 is marked other then "naturel", or items 23a or 28a-f show or other traumatic event, the Madical Examination in must be motified at	Completed b	15. Decedent's Education (Specify only highest grade completed) (GElementary/Secondary (0-12) College (1-4or 5+)	ocedent's Usual Occupation ive kind of work done during most of work e. DO NOT use retired)	unk 16	6b. Kind of Business	/Industry un
ם כ	Mental Hygie arked other t	To Be Co	8 17. Father's Name (First, Middle, Last) Wilmer Cannon		(First, Middle, Ma	aiden Sumame)	
Mar	Ith and Men 27 Is marke traumatic		19a. Informant's Name/Relationship ( <i>Type</i> , <i>Print</i> ) 19b. M.  ECI Revells Neck Road Westover, MD 2	ailing Address <i>(Street and Number or Rura</i> 21817	al Route Number, (	City or Town, State, a	Zip Code)
w,	permit. Fages I and Department of Health Important: If item 27 any Injury or other tr		20a Method of Disposition 20b. Place of Di		Date 20	c. Location - City or	Town, State
	Department Important: any injury once.			22. Name and Address of Facility State Anatomy Board Ballimore, MD 2120		Baltimore	Street
F	hysician		23a. Part Enter the disease, or implications that caused the death. Do not shoot or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	enter the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
E	/Medical Examiner		Due to (or as a consequence of):	S			10 yrs.
,00,	nysician and he burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b.  Due to (or as a consequence of):	S C.			
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rus, r	wiequiles inat been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did toba 1 ☐ Yes	. /	o the cause of death? robably 4 Unknown
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	After this funeral d	ation; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manne of Death 1 Natural 5 Pending 2 Accident investigation  1 Accident Hospital: 1 Inpatient 2 ER/Outpa  28a. Date of Injury (Month, Day Year)  Injure  1 Accident	tient 3 DOA Cther: 4 Nursing Ho	me 5 Residen 28d. Describe how	ce 6 Other (Spe	ocify) PRLSON
DIVISION .	io tre nospiee of attending Frighting Principal within 24 bours after death. To the Funetel Directors After the completely filled in by the funeral	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
:	within 24 hours after to the Funerel Directory of the Funerel Directory completely filled in I	Medicai (	29a Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, d 2 Medical Examiner: On the basis of examination and/o	eath occurred at the time, date and place, r investigation, in my opinion, death occur	and due to the cau ed at the time, dat	ise(s) and manner a e and place, and du	s stated. e to the cause(s)
1	within To th compi	Me	29). Signature and title of pertifier $\mathcal{H}\mathcal{D}$ .	29c. License number  D 25859	296	d. Date signed (Mont	th, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print)		1	21890
	Sta Registi		DAVID MATHIS MD ECT R.  31. Date filed (Month, Day, Year)  JUN 2 5 2007  32. Hegistrar's Signatore	PO, Print) EVELLS NECK	WES	TOVER,	(17)

State of Maryland / Department of Health and Mental Hygiene 20367 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 200<sup>Year</sup> **Physician** 19, June 4:00 A M Vagianos D. Papageorgiou /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4911 Fait Avenue Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 2 F Greece 89 218-62-4233 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hygiene.

ent: If Item 27 is marked other than "naturel", or iteme 23a or 28a-f ehow ury or other treumatic event, its Medical Examinal must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Baltimore City 1 Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4911 Fait Avenue 21224 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ☐Yes 2X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐XNo f Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Cook Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Anastasia Unknown Demetri Papageorgiou 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4911 Fait Avenue, Baltimore, MD 21224 Helen Papageorgiou-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ty Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or once. 6-23-07 Oak Lawn Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facili Bradley-Ashton Funeral Home, 21. Signature of Funeral Se PA, 2134 Willow Spring Road, 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician o Can ava /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): lew requires that the death certificate be executed ettending physicien and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4□Pregnant at time of death 5 Other (specify) ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 Yes 2 No 3 Probably Completed 08eu Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificete has autopsy 2 🗆 No 1 Yes or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one Hospital: 1 Yes 2 No Other: 4 Nursing Home ၉ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) After thi 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No death. filled in by the f 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours e To the Funeral ( 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 6/20/0-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HArford Rd Suite 100, Parkville, MD 21234 8113 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 2 5 2007

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 06:44 AM Samuel Rogers, Jr. 20 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL BALTIMORE GOOD SAMARITAN NA If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1√2 M 2□F Days Hours Min Director 215-76-5433 2-24-1961 46 Md Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow injury or other treumatic event, the Medical Examiner must be notified at 1 X Yes 2 ☐ No Md. Director NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "netural", or items 23a 437 N. Kenwood Avenue 21224 IISA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 3√☐ No Specify: ρ Specify: Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16h Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "ne any injury or other treumatic event, Ite Madig once. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Disabled llth grade NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Rogers, Sr. Lucille 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucille Person Mother 437 N. Kenwood Ave., Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Carmel Cem. 6-26-07 Dundalk, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. la 1101 E. North Ave., Baltimore, Md. 21202 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEPSIS WITH MULTIORGAN /Medical Due to (or as a consequence of): Examiner URINARY TRACT PHEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and the for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) be detached 9□Unknown 9 □Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No 1 Yes 20 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 ☐ No **Thpatient** 2 ER/Outpatient 3 DOA ctor: After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD RESODO 06/21/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRACHI JOG GOOD HOSPITAL, BALTIMORE, MD SAMARITAN 32. Registrar's Signature 31. Date filed (Month, Pax, Year) JUN 2 5

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Terry Rutherford 23 2007 /Medical June 7:15a 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death Examiner Carroll Hospice Dove House Carroll Westminster 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 21 F 215-03-6028 93 Yrs. Sept Director 1913 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Carroll Westminster Director 1 ∐Yes 2√∑No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 St. Mark Way Apt 405 21158 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ Specify: 3√z Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Proctor & Gamble secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank R. Terry Anne E. Konradi ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry R. Flores (daughter) 1602 Dahlia Circle, Dayton, NJ 08810 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-25-07 Sykesville, MD All County Cremation 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee any ir Daige Spaight Stenbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Physician Assorbetura disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to influed at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner i necords, P.O. Box 68760, E.

The law requires that the death certificate be executed New G From Due to (or as a consequence of): as the burial-trar and Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month 4☐Pregnant at time of death 9☐Unknown Day Year 5 ☐ Other (specify) 9 Unknown signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 □ No 3 ☐ Probably 4 ☐Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 1 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify). Dove the 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 No neral Director: / / filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge death octal

Medical Examiner: In the basis of examination and/or investiga 29a Certifier d at the time, date and place, and due to the cause(s) and manner as stated. Medical gation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 30. Name and address of person who (Type, Print) Year, State 2017 Registrar

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. gistrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 9:35 pM Josephine T. Spann June 24 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Oak Crest Village Nursing Home Carney Baltimore 8. Date of Birth (Month, Day, Year) Sept. 17, 1916 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Months Days 213-07-2666 1 □ M 2 🛛 F 90 Md. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Carney Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8830 Walther Blvd. Apt. 122 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 10 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Carlin Mary Hock 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pat Becker daughter 2417 Fairway Dundalk Md. 21222 20a. Method of Disposition 1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State June 25 Bayview Crematory Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Si ma ure of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home of Dundalk 7110 Sollers Point Rd. 21222 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia e Cause (Final disease or condition resulting in death) Bacterial pines mo nia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 0654500/100 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ onknown polmonary diseus & 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ № 24a. Was an 2 TNo 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical **Examiner** Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit

Physician

/Medical

Examiner

**Funeral** 

Director

28a-f show

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"natural", or items 23a

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any lidury or other traumatic event, the Medical Examines once.

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Director

Funeral

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Completed

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death with the Maryland

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page 2 s

Examiner Physician/Medical þ Completed Be Certification: To

in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown Dementic 1 Yes 2 No

3 Suicide

(Check only one)

29a, Certifier

Medical

25. Was case referred to medical examiner? 27. Manner of Death 1 Natural 2 Accident

5 Pending investigation 6 Could not be determined 4 Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Parkville

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

JUN 2 5 2007

29c. License number 058646 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8900

Monias 31. Date filed (Month, Day, Year)

32. Registrar's Signature

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State Registrar

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			Registrar  1. Decedent's Name (First, Middle, Last	<u> </u>		tillicate of t	Jeani	2. Date of Death	J. No.	3. Time of Death
	Physic		Gabriela Sebo	•				Month	Day Year 2 ( 200	
	/Medi Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	JUNE	4c. County of Dea	
	LXaiiiii	iei	Union Memorial H			Balti			N/A	•••
	Funeral		5. Social Security Number 6. Se	7. Age (In y	rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		thplace (State or Foreign
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	pu *		Usual Residence of Decedent  10a. State 10b. County	100	City, Town or Lo					
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	with a or	ā	6802 Roberts Ave	_		10f. Zip Code	2122		g. Cilizen of What C USA	ountry ?
	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Itama 23a or 28a-1 ahow avant, the Medical Examinar must be notified at	Funerai	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of Hi			14. Race - Am	erican Indian
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7	within lene. than	ig.	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	)	9	**********	
7	filed w Hygier Ither th		12 yrs.			Housewife			Home	
Maryland 21215-0036	be fill	Be	17. Father's Name (First, Middle, Last)  Jan Omasta					e (First, Middle, Ma	oacherova	
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Mai	12 s har Teau		19a. Informant's Name/Relationship (Ty Victor Sebo Husba	, , ,		ng Address <i>(Street a</i> )2 Robert:		al Route Number, ( Dundalk Mo	City or Town, State,	Zip Code)
	1 an Heat em 2 ther		20a. Method of Disposition		. Place of Dispo				Oc. Location - City or	Town State
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Z	Dhuaisina		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.					"	Interval Between Onset and Death
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Box	ath c	lan	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of preg	etal death 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year
o	the e	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	rdeath 5∟	Other (specify)				July 1 July 1
σ.	that I	P.	Part II. Other significant conditions cor	tributing to death but not r	esulling in the ur	nderlying cause give	n in Part I	23e Did toba	con use contribute t	o the cause of death?
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Ö	v req been shou	ete	RENAL IN							•
Ä	ne fav has ge 2	m d	KENAC IN	SOM CIEVE				24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
B	n: Ti ficete or. pa	e Co	25. Was case referred to medical					1 ☐ Yes 2		2 □ No
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ō	Phy or this oral d	: To	27. Manner of Death	28a. Date of Injury	28b. Time of	28c, Injury Work	4 ∐ Nursing Ho	me 5 Resident 28d. Describe how	ce 6 Other (Spe	icify)
<u>0</u>	nding tth. :: Afte	i i	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		? ′es 2 □ No			
Division of Vital Records, P.O.	Attar r dea ector by the	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At	home, farm, str	eet, factory, office			et and Number or R	ural Route Number,
ă	s afte	Certification;	4   Homicide	building, etc. (Spec	city)			City or Town,	State)	
	papit hour uners ly tille		29a. Certifier Certifying Phys	sician: To the best of my k	nowledge, death	occurred at the tim	e, date and place,	and due to the cau	se(s) and manner a	s stated.
	To the Hospital or Attanding Physician: The law requires that the death certificat within 24 hours after death. within 24 hours after death. completely filled breath: completely filled in by the funeral director, page 2 should be detached for use as th	Medicai	(Check only 2 Medical Examilations)	ner: On the basis of exami and manner stated.	nation and/or inv	estigation, in my op	inion, death occurr	ed at the time, date	and place, and due	to the cause(s)
,	To To To To To To To To To To To To To T	2	29b. Signature and title of certifier		MA	29c. License			. Date signed (Mont	
			30 Nume and address of person who co		MD	D	41637	J	UNE 2	1 2007
	le		30 Him e and address of person who co	mpleted cause of death (It	em 23a) (Type,	Print) (	NioN	MEMOR	CIAL NO	SPITAL, MD
			SACIM	I K/	CKI	MD				
	Sta Registr		31. Date filed (Month, Day, Year)	I R/	S. Age	met.				
1.5			0011 0 0 CO	A CONTRACTOR OF THE PARTY OF TH						

### 07-04720 Victoria Schaffer

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		icate of D		ental Hygiene	Reg. No.	007 200
Physicia Medical Exami		Decedent's Name (First, Middle,Last)				2. Date of D Month	eath	3. Time of Death
wedicai Exami	ner	Victoria  4a. Facility Name (if not institution, give street and number)		Schaffe		June 20		1750 hrs
		1612 Charlotte Avenue			City, Town, or Locati altimore	on of Death	4c. County	of Death
Funeral			e (In yrs. last b				Birth(MM/DD/YYYY	9. Birthplace (State or
Director		217–38–2386 1_M 2XF		65 Yrs.	Months Days Ho	urs Min. Februa	ary 9, 1942	Foreign Country) MD.
any		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tox	wn or Location				10d. Inside City Limits
ě	Ŀ	Maryland N/A		Baltim	ore			1 XYes 2 No
Aaryland 28a-f show 1 at once,	Director	10e. Street and Number	<u>.                                    </u>	10	f. Zip Code		10g. Citizen of Wi	hat Country?
th the M 23a or 2 notified		1612 Charlotte Avenue			2122	1	US	SA
72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho af Examiner must be notified at once	Funeral	11. Marital Status  1 Never Married 2 X Married Armed Forces?	)			Origin? (Specify Yes or can, Puerto Rican, etc.)		e - American Indian, Black, e, etc.
ifter de Il", or ner m		3 Widowed 4 Divorced If Yes, Give Year	X <sub>No</sub>	1 Yes	s 2 X No spec	ify:	Specify:	White
hours a	ed by	15. Decedent's Education (Specify only highest grade com	npleted) 16		Isual Occupation (Gi	ve kind of work done	16b. Kind of Bu	usiness/Industry
	Completed	Elementary/Secondary (0-12) College (1-4 or 8	5+)	House		or use remed)	Q == 11=	-
15-0036 filed within 72 Hygiene, ad other than 's, the Medical,	Com	17. Father's Name (First, Middle, Last)		nouse		her's Name (First, Middle	Own Ho	
MD 21215-0036 to 2 should be filed within 7 th and Mental Hygiene. In 27 is marked other than umatic event, the Medica	Be	Arthur Cobb			Bai	rbara Cobb		,
hour nd h	ပ	19a. Informant's Name/Relationship (Type, Print )				lumber or Rural Route N		
ore, MD 21218 ges I and 2 should be fill t of Health and Mental H : If item 27 is marked it		Ray E. Schaffer Husband  20a. Method of Disposition			(Name of cemetery,	Avenue, Balt	•	- City or Town, State
imore, MD 2 Pages 1 and 2 shoument of Health and 1 tant: If item 27 is roor or other traumarie		1 Burial 2 X Cremation 3 Removal from Sta	crem	natory or other p Lew Cren	lace)	June 23,	Baltimo	
Baltimore, ME permit. Pages 1 and 2 s Department of Health an Important: If item 27 injury or other trauma	- 3	4 Donation 5 Other Specify:  1. Signature of Funeral Service Licensee						
		who med of	<del> </del>	7110	Sollers	eral HOme Of Point Road,	, Dundalk	,MD. 21222
Physician /Medical	n 11	23a Part I. Enter the disease, or complications that caused folium. List only one cause on each line.				s cardiac or respiratory a	arrest, shock, or he	Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic (Due to (or as a conse		cular Diseas	e			Death
	L	Sequentially list conditions, b						
	Examiner	if any, leading to immediate  Due to (or as a consection of the co	quence of):					
ansit g · cly		events resulting in death) Last	quence of):					
exectian an	Medical	d. UNPENDED AMENDED						
760, icate be physic the bur		IF FEMALE: 23c. If yes, outcom	ne of pregnanc	у			23d. Date of	delivery
Box 687 e death certifi the attending ed for use as t	ician/	past 12 months?	time of death	2 Fetal de	eath 3Ecto (Specify)	ppic pregnancy	Month	Day Year
Box ne death c the atten	Physi	1 Yes 2 No 9 Unknown 9 Unknown						
res that the d	by P	Part II. Other significant conditions contributing to death	but not result	ing in the under	lying cause given in			bute to the cause of death?  Probably 4 Unknown
ords, w require is been sig should be	eted							Vere autopsy findings available
of Vital Records, ng Physician: The law require ther this certificate has been as meral director, page 2 should I	Completed					aut	opsy p formed? o	prior to completion of cause of death?
Vital Recolysician: The law his certificate has director, page 2 sl	ပ္ပို	25. Was case referred to medical			26.Place of Dea	th (Check only one)	3 2 <b>✓</b> No 1	Yes 2 No
Vita hysicia this ce	8	examiner?  1 ✓ Yes 2 No Hospital: 1 Inpatier	nt 2 ER/	Outpatient 3	DOA Other	Nursing Home 5	Residence 6	Other: Scene
1 of ding Pt After	i.i	27. Manner of Death  1 Natural  Natural  28a. Date of Injur (Month, Day,Ye	y 28b ear)	. Time of Injury			e how injury occurr	ed
Division as a free death.  In Director: A led in by the fulcion by the fulcion as	Cati	2 Accident Investigation	Up/ At home	form atrost for	1 Yes 2 tory, office building.		(Ot	
Divis Hospital or A 24 hours after Funeral Dire	Certification:	3 Suicide 6 Could not be determined (Specify)	ary - At Home,	iaiii, sueet, iat	cory, office building,	or Town,		er or Rural Route Number, City
To the Hospital within 24 hours To the Funeral completely filled		29a. Certifier 1 Certifying Physician: To the best of my	knowledge, d	eath occurred a	t the time, date and	place, and due to the ca	use(s) and manner	as stated.
To the Hos within 24 h To the Fur completely	ij١	one) 2 Medical Examiner: On the basis of exam	nination and/or	r investigation, i	n my opinion, death 29c. License numb			
	ĕ	29h Signafute and title of continer						
	Medical	29b. Signature and thie of certifier				er		ed (Month, Day, Year)
		29b. Signafure and thile of certifier  30. Name and address of person who completed cause of de	ath (Item 23a	)	O.C.M.E.	er	June 21, 20	
3		AKKIN M	aminer	•				

			For State	State of Maryla		epartment of F Certificate of			7111	7 20374
		9	Registrar     Decedent's Name (First, Middle, Last	)			Dealli	2. Date of Dea	Reg. No.	3. Time of Death
	Physici		WILEY ZU	IELYN	SA	NOFRS		Month		ear I A I I
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Dea		4c. County of	
	• Kest		Anne Arundel Medi	cal Center		Annapo1	is		Anne A	Arundel
P.	Funeral		5. Social Security Number 6. Sec.	IM 2Γ <b>1</b> F	rs. last birth	Months Days	If Under 24 Hrs Hours Min		, Year)	Birthplace (State or Foreign Country)
0.	Director		219-01-7366 Usual Residence of Decedent	9	1 Yr	5.		June 1	1, 1916 N	Maryland
	yland now at		10a. State 10b. County	10c.	City, Town o	or Location				10d. Inside City Limits
	a-fsk	ctor	MD Anne Arun	del A	nnapo	lis				1 ☐ Yes 2☐ No
	ith the or 28 e not	)ire	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	at Country?
	ath w	ral	1602 Father Urban	Lane	_	214	109		USA	
	er de Items ner m	<b>Funeral Director</b>	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S.	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	ispanic Origin? ( an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		American Indian, White, etc.
36	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ont, the Medical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates;		1 ☐ Yes 2 🌠 No	Specify:		Specify:	white
2-0036	2 hot	ted	15. Decedent's Edu	cation	16a. D	ecedent's Usual Occup	ation		16b. Kind of Busir	ness/Industry
7	thin 7 le. lan "r	Completed	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	- (G	Give kind of work done fe. DO NOT use retired	during most of wo d)	orking		
7	ed wi ygier ner th t, the	Con	12	0	ho	usewife			own	home
Maryland	m = 0 %	Be	17. Father's Name (First, Middle, Last)  Harry Webster Stu	hha				me (First, Middle,	Maiden Surname)	
Ž	hould of Me mark matic	은	19a. Informant's Name/Relationship (Ty		10h N	laiting Address (Ctreet		e Wiley	0	
	alth an 27 is rrau		Carla Garner/daug		160	lailing Address <i>(Street</i> 2 Father U1	ban Lan	e Annapol	r, City or Fown, Sta . <b>is,</b> MD	ate, Zip Code) 21409
more,	es 1 a of Hea		20a. Method of Disposition	201	. Place of D	isposition (Name of crematory or other place	re)	Date	20c. Location - Cit	y or Town, State
Ĕ	Page ment ant: It ury o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 🖾 Donation 5 ☐ Other (Specify)	emoval from State	,					
Bait	permit. Pages i and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic es once.		21. Signature Funeral Service Licens	ade Direct		22. Name and Addres	omy Boar	d 655 W.	Baltimor	e Street
ı			25a. Part1. Inter the disease, or compli	cations that caused the de		Baltimore, enter the mode of dyin			est.	Approximate
	Physician		Immediate Cause (Final	ne cause on each line.	oun	win				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to ( as a cons	equence of	-/	() 4	/ 5		Ziveda
	Examiner		Sequentially list conditions,	Er	rel >	tze	alz 1	rem		4 len
	Sit ed	Examiner	rating leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons	equence of).		,			
	xecut and ul-tran	хап	that initiated events resulting in death) Last	Due to (or as a cons	equence of):					
00/00	icate be executed physician and s the burial-transit	edical E								
^	tificat g phy as the									
Š	th cer tendin r use	an/N	200. Was decedent pregnant	3c. If yes, outcome pf preo 1 ☐ Live birth 2 ☐ Fo		3 ☐Ectopic pregnancy			23d. Date o	f delivery
5	uires that the death certific signed by the attending p d be detached for use as	Physician/M	in the past 12 months? 1 □ Yes 2 ┗ No 9 □ Unknown	4☐Pregnant at time o	f death	5 Other (specify)			Month	Day Year
Ĺ	hat the	Phy	Part II. Other significant conditions con	tributing to death but not r	oculting in th	a underlying source size	on in Daniel	00 - Dida-		
cords,	signe d be	d by	LVH.	and any to death but not i	esulang ar ar	e underlying cause give	m m rant I.	23e. Did tot		te to the cause of death? ☐ Probably 4 ☐Unknown
5	w requ	Completed				-				
ב כ	The lar e has age 2	ошо						24a. Was a autops perforr	y prio	re autopsy findings available r to completion of cause of th?
g	an: T tificat tor, pa		25. Was case referred to medical				26 Place of Do	1 Yes 2	2 No 1 🗆	Yes 2□No
>	nysici nis cer direc	o Be	examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 Inpatient 2	☐ ER/Outpa	tient 3 DOA Othe		ath <i>(Check only on</i> Home 5 ☐ Reside		Specify)
5	ng Pr fter th	Ë.	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Tim Injui				w injury occurred	Ореспу
2	tendi eath. for: A the fu	catic	2 Accident investigation 3 Suicide 6 Could not be			M 1 1 1	res 2 □ No			
5	or At after d Direc in by	Certification:	4 Homicide determined	28e. Place of injury - At building, etc. (Spe	home, farm, cify)	street, factory, office		28f. Location (St. City or Town	reet and Number o , State)	r Rural Route Number,
	spital hours ineral y filled	S	29a. Certifier 1 Certifying Phys	ician: To the best of my k	nowledge, de	eath occurred at the tin	ne, date and place	, and due to the ca	ause(s) and manne	er as stated.
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	one)	ner: On the basis of exami and manner stated.	nation and/o	r Investigation, in my o	oinion, death occi	urred at the time, d	ate and place, and	due to the cause(s)
	With Col.	-	29b. Signature and title of certifier	A.	4 A	29c. License	number	29	9d. Date signed (N	fonth, Day, Year)
		-	20 Name and address of assess	men a	00:1 T	1	V14-	28	June 1	0,100)
			30. Name and address of person who con	ripieved cause of death (It	em 23a) (Typ	De, Print) DEFIO	NSE H	GHWA4	ANNAG	OUS MOLIYOI
	Stat	е	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	1	- 1'(	41	1	
	Registra	ır	JUN 2 5 2	007 Blocks	J.	Come				

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Ma	arylano /		ificate of i		wentai n	ygiene Reg. No		
	Physici	an	Decedent's Name (First, Middle, Las		h o ~ ~ o ~	D	S M		2. Date of I	Death Da	y Year	3. Time of Death
	/Media	al	Sr. M. Germana  4a. Facility Name (If not institution, give		berger			Location of Deat	June	20,	2007 County of Death	3:00AM
	Examir	er	The Villa	i street and number)			Baltim		n		altimo:	
	Funeral Director		220 34 0321	□M 2√E]F	e (In yrs. last b 96		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of 8 (Month, 6 5 - 5 -	Rinth	9 Rinth	place (State or Foreign Intry) MD
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tox	wn or Loca	ation					10d. Inside City Limits
	Mary f sho	to	MD Baltimo	ore	В	alti	imore					1 □ Yes 2 □ No
	th with the 23a or 28a	ai Dîrec	10e. Street and Number 6806 Bellona	Avenue	1		10f. Zip Code 2 1 2 1	2		_	tizen of What Cou	intry?
980	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iteme 23e or 28e-f ahow any follury or other traumatic avant, the Medical Examinar must be notified at ADDE.	by Funeral Director	11. Marital Status  The Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	Ever in U.S. No		as Decedent of H Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or fo Rican, etc.)	No-	14. Race - Amer Black, White Specify: W	
21215-0036	ithin 72 h	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)			(Give ki life. DC		during most of wor l)		16b. K	Kind of Business/Ir	·
121	iled w Hygier ther th	Cor	1 2 17. Father's Name (First, Middle, Last)	4		Tea	acher/L	ibraria		llo. Admirtus	Educat	ion
anc	d be fi	o Be	John Strassbe	raar				Madge				
Maryland	shoul ind Me mark	To	19a. Informant's Name/Relationship (7		ious 19	b. Mailing	Address (Street a	and Number or Ru	ırai Route Num	ber City	or Town State Zi	ip Code)
Σ	end 2 selth a n 27 is		Sisters of Mer	cy- Ord	er  13	300 1	E. Nort	hern Pa	arkway 	'Bal	Ltimore	, MD 21239
Baltimore,	Pages 1 nent of He ant: If itan ury or oth		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify		cemete	ery, crema 11aw 1	tion (Name of Itory or other plac n Cemet	ery	Date	Wo	ocation - City or T o o d 1 awn	, MD
Balt	permit. Depertr Imports any Inj		21. Signature of Funeral Service Light	***							oad, 21	neral Home 222
			23a. Part1. Enter the disease, or comp shock, or heert failure. List only of	olications that caused one cause on each lin	the death. Do	not enter	the mode of dyin	g, such as cardiac	or respiratory	arrest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)				care	dio vasa	ulan	dise	ak	Onset and Death
	Examiner		1	Due to (or as	a consequence	of):						
	-	Jer	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying	b. Due to (or as	a consequence	of).						
	scuted ind transit	ami	Cause (Disease or injury that initiated events resulting in death) Last	c								
68760,	tificate be executed ig physicien and as the burial-transit	edicai Examiner	resulting in death) East	d.	a consequence	of):						
	ding p		IF FEMALE:	23c. If yes, outcome	of pregnancy							
P.O. Box	The law requires that the death cer sie hes been signed by the attendin page 2 should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal deat		ctopic pregnancy Other <i>(specify)</i>				23d. Date of deliv Month	rery Day Year
rds, P	quires that n signed b uld be deta	<u>۾</u>	Part II. Other significant conditions or	ontributing to death be	ut not resulting	in the und	erlying cause give	en in Part I.		l tobacco	_	the cause of death?
Division of Vital Records,	8 8 6	Completed							per	opsy formed?	prior to co death?	opsy findings available ompletion of cause of
ita	lan: 'atifice	BeC	25. Was case referred to medical examiner?					26. Place of Dea		2 No	1 ☐ Yes	2   No
<u>&gt;</u>	Physic this ce al dire	유	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie		_	3□ DOA Othe	4 🖾 Nursing n	lome 5□Re	sidence	6 ☐Other (Speci	rfy)
50	ding P. After funera	ijon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injui (Month, Da)		Time of Injury	28c, Injury Work	vat k? Yes 2 □ No	28d. Describe	e how inju	ry occurred	
)ivisi	or Attanding Physiclan: siter death. Diractor: After this certifice in by the funeral director, i	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined			arm, stree		165 2 10		(Street ar	nd Number or Run e)	al Route Number,
_	To the Hospital or Attending Physician: The within 24 hours eliter death.  To the Funeral Director: After this certificete h completely filled in by the funeral director, page	Medical Ce	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	vsician: To the best of iner: On the basis of and manner sta	examination a	je, death o	occurred at the tim stigation, in my op	ne, date and place pinion, death occu	, and due to th irred at the time	e cause(s e, date an	) and manner as : d place, and due !	stated. to the cause(s)
	To tha within Fo tha comple	Me	29b. Signature and title of certifier				29c. License	number		29d. Da	ite signed (Month,	Dey, Year)
}			mier-Do	1 Lala	4		0	3186	5		6/21/	07
	3		30. Name and address of person who c				int) 2/ N.	Entan	st.	Bal	timore	07 md 2/20/
	Sta Registr	_	mion-loov Krt. 31. Date filed (Month, Day, Year) JUN 2 5 2007	32. Registra	ar's Signature	bart	j i					

			For	State of Maryland	d / Depa	rtment of H	lealth and M			7 20376
			State Registrar		Cer	tificate of I	Death		Reg. No.	105.00
**	Physicia **/Medic	an	1. Decedent's Name (First, Middle, Las SR, MARY ROSE		S.H.			2. Date of De Month	19 20	
	Examin		4a. Facility Name (If not institution, give				Location of Death		4c. County of E	Death
			MERCY MEDICAL (		at hirthday)	If Under 1 Year	MORE C3	8. Date of Bir	th 9	Birthplace (State or Foreign
America .	Funeral Director		5. Social Security Number  212-12-2264  Usual Residence of Decedent	7. Age (In yrs. le	3 Yrs.	Months Days	Hours Min.	(Month, Da	9 1914	Country) MD
	land ow	ŀ	10a. State 10b. County	10c. City,	, Town or Lo	cation				10d. Inside City Limits
	Mary -f sho	ţ	MD Baltimo	ore Bai	ltimo	re				1 □Yes 2 No
	r 28a	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	t Country?
	th wit 23a c ast be	a D	6806 Bellona A	Avenue		21212			USA	
	r dea	ne	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Race - A Black, V	American Indian, Vhite, etc.
36	s afte , or h amin	by Fi	1 ☑Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates:		1 □ Yes 2K No	Specify:		Specify:	White
Ö	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show 'deal Examiner must be notified at	q pe	15. Decedent's Ed		16a. Dece	dent's Usual Occup	ation		16b. Kind of Busin	ess/Industry
5.	in 72 n "na Ne Ic	plet	(Specify only highest gra	de completed)	(Give life. I	kind of work done DO NOT use retired	during most of work d)	ing		
21215-0036	filed within Hygiene. Ither than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 6+	E	ducator			Private	Schools
pu	should be filed within 72 hours after death with the Marylan ad Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items be notified at matte event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name Dora D		, Maiden Surname)	
<u>ya</u>	2 should be fi and Mental I Is marked ot aumatic ever	으	Andrew J. Simm							
Maryland	S S S		19a. Informant's Name/Relationship (7 Sisters of Mer			•			er, City or Town, Sta	
	ges 1 and 2 it of Health If Item 27 i		20a. Method of Disposition	order				Date	20c. Location - Cit	more, MD 212
آور			1 Bunal 2 □ Cremation 3 □	Hemovai from State		sition (Name of matory or other plac	1	0.7		
Baltimore,	permit. Page Department Important: If any Injury o		4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Licen	1,44.0	odlav		6-22			awn, MD Funeral Home
Ba	permit. Page Department of Important: If any Injury or once.		MANUAL A						ng Road,	
	<b>5</b> 000		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the death						Approximate Interval Between
100	Physician		Immediate Cause (Final disease or condition	ACUTE MY						Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ	ence of):			<u> </u>		
	Examiner		Sequentially list conditions	b. ATHEROSCLE		CARDIOV	ASCULAR L	JISEAS!	Ē	
V	D to	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of):					
k,	and -trans	Examiner	that initiated events resulting in death) Last	c Due to (or as a consequ	ence of):			***		
760,	te be executed ysician and e burial-transit	calE			,					
687	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edic		d						
Box	n certi nding use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregnar	ncy	75-to-i			23d. Date of	-
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 🗷 No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		]Ectopic pregnanc ] Other (specify) _	у		Month	Day Year
P.O.	that the de ned by the a detached f	hys	9 ☐ Unknown							4.10
	w requires that been signed to should be deta	by F	Now LOW VILLE IVE	-	_		en in Part I.			ite to the cause of death?
ord	equir sen si ould	ted	NONLONVYLSIVE	STATUS LPILE	PTIC	45				☐ Probably 4 ☐ Unknown
ec	law ras be	ple						24a. Was	ppsy pric	re autopsy findings available or to completion of cause of
<u>=</u>		Completed							orméd? dea 2⊠No 1□	ith?  Yes 2□ No
Vita	ysician: The law is certificate has be director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		ot 3DDOA Oth	26. Place of Dea			
o	> .∞ 0	. To	1 ☐ Yes 2 No 27. Manner of Death	1 Inpatient 2 ☐ I	ER/Outpatie	II 3 DOX	4 LI Nursing H		how injury occurred	(Specify)
on	ding h. After funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wo	rk? ]Yes 2∐No		, , , , , , , , , , , , , , , , , , , ,	
Division or Vital Records,	Attending Physician: r death. ector: After this certifics by the funeral director, p	fica	3 Suicide 6 Could not be	28e. Place of injury - At ho	me, farm, st	reet, factory, office				or Rural Route Number,
ó	al or satter	Certification:	4 ☐ Homicide determined	building, etc. (Specify	′/ 			Ony or ro	own, State)	
	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 ★ Certifying Ph (Check only one) 2 Medical Exar	nysician: To the best of my knowniner: On the basis of examination and manner stated.	wledge, deat tion and/or in	th occurred at the to nvestigation, in my	ime, date and place opinion, death occu	, and due to the rred at the time	e cause(s) and mann e, date and place, and	er as stated. d due to the cause(s)
	ro the vithin ro the comple	Me	29b. Signature and title of certifier	71		29c. Licens	se number		29d. Date signed (	Month, Day, Year)
	->-0		And hunder a.	Kanlo In D		D53	3517		JUNE 1º	1,2007
	2		30. Name and address of person who	completed cause of death (Item	23a) (Type,	Print)				
	ر		ARNEL MENDOZ	A TAGILE MD 3	OI SAIN	M PAUL PLA	CE BALTI	MORE !	MARYLAND.	21202
	Sta Regist		31. Date filed (Month) Pey, Year)	32. Registrar's Signa	ture	uff)				

DHMH 17 Rev 1/2001

n 24 hours af I**e Funeral D** Iletely filled ii within 2 To the I complet

31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

2

29b. Signature and title of certifier

ILIA

30. Name and address of person who completed cause

CEBALLOS

JUN 25

**ORIGINAL** 

of death (Item 23a) (Type, Print)

32 Registrar's Signature

29c. License number D25886

7601 OSLER DRIVE TOWSON, MARYLAND 21204

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** TUTNER STELLA 3:16 P.M JUNZ 24, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3529 £. BAltimore FAIRMOUNT Avenue If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 SF 217-24-6308 **Director** 1 ARY AND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Baltimore Funeral Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by Wh,+ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (9-12) College (1-4or 5+) OWN HOME to me maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Komorowsk ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; If Item 27 is any Injury or other train 3529 DONALD E-FAIRMOUNT URNER-SPULSC 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State Centery June 28, 2007 BAH I MORE, MAS 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ANNINO Joseph 263 CONKLING St. U Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Merchion **Physician** yeus Myocardial /Medical Due to (or a a consequence of): Examiner Dementic 2 years Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical as the l IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No this certificate Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To completely filled in by the funeral 27. Manner of eath
1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred after death. Director: After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital or To the Hospital within 24 hours a To the Funeral C 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Res-000 Humon, Medical Dochor

State Registrar

Johns Hopkins Hospital, 600 N Wilte Street, Baltimore MD 2128 Z Mignel Munoz 31. Date filed (Month, Day, Year) JUN 2 5 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 2320 liftord Tait 20 2007 Une /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) (enter Examiner Brooke Grove Rechabilitation and Nursing Montgomery Sardy >pring If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day. 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 X M 2 ☐ F 84 077-18-7985 Connecticut Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County items 23a or 28a-f ehow cer must be notified at 1 ☐ Yes 2 No Maryland Montgomery Director Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11506 Hitching Post Lane or Items 23a 20852 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? เมนา 11 Marital Status Black, White, etc. WWII 1 X Yes 2 No If Yes, Give Year or Dates: Pages 1 end 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify: Korea ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) Cotlege (1-4or 5+) Judge U.S. Government and Mental Hygier I 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Clifford Tait Elizabeth Shipley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) If Heelth ? Margaret A. Tait/Wife 11506 Hitching Post Lane, Rockville, MD June 24, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Depertment of
Importent: If it
eny injury or o 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Montgomery Crematorium 2007 Bethesda, Maryland 4 □ Donation 5 □ Other (Specify) Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland 20850 21. Signature of Funeral Service Licensee Ulllan M01173 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or leach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia Due to (or as a consequence of): /Medical Examiner Due to (dr as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physicien: The law requires that the death certificate be executed heimer Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 3 Probably 4 Unknown 1 Yes 2. No 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 ☐ Yes 1 ☐ Yes 2ENO After this certification, funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1. Natural 5 Pending 1 Yes 2 No efter death. I Director: Ald in by the fu investigation 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours e To the Funerel C completely filled i 29a. Certifier Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Une 21, 2007 ATTENDING PHYSICIAN address of person who completed cause of death (Item 23a) (Type, Print) Frace Brooke Huffman, 4.D. 18100 Stage School Food Sandy Spring 32. Begistrar's Signature 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryla		artment of I		Mental Hy	giene	17	20380
	Physici /Medi Examir	cal	1. Decedent's Name (First, Middle, La Kathleen L. Ullrich 4a. Facility Name (If not institution, giv Fairhaven Nursing Hon	re street and number)		4b. City, Town, o	or Location of Dea	2. Date of De Month 06/22/	Day 2007 4c. County		3. Time of Death 08:30 p <sup>M</sup>
	Funeral Director		5. Social Security Number 6. S	Sex 7. Age (In y	rs. last birthday, 9 Yrs.		If Under 24 Hrs Hours Min		ay, Year)		
baltimore, maryland z1z15-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depurtment of Health and Mental Hygiene. Depurtment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23s or 28s-f show stry injury or other traumatic event, the Medical Examt and cust be notified at once.	To Be Completed by Funeral Director	10a. State 10b. County  MD Carrol 1  10e. Street and Number  7200 Third Avenue  11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced  15. Decedent's E (Specify only highest gr.  Elementary/Secondary (0-12)  10  17. Father's Name (First, Middle, Last  Alexander Anderson  19a. Informant's Name/Relationship (  Kathy Miller, Daughte  20a. Method of Disposition  1 X Burial 2 Cremation 3 L 4 Donation 5 Other (Specien)  21. Signature of Funeral Service Lice	12. Was Decedent Ever in Armed Forces?   1   Yes   2 M No   1 Yes, Give Year or Dates: ducation ade completed)   College (1-4or 5+)   Type, Print)   Yr   20th   Removal from State   Yr   Pe	16a. Dece (Give life.  Home  19b. Maili  10332  Place of Dispresentary, cre arkwood Co	Unit of the plan	specify:  Specify:  Dation during most of word  18. Mother's Na  Catherine and Number or R  Can Road, Wate	Epecify Yes or Norto Rican, etc.)  briking  me (First, Middle  Coughlin  ural Route Numb  codstock,  Date	Specify  16b. Kind of Bu  Own Ho  Maiden Surnam  er, City or Town, MD 21163 20c. Location -	What Count  Se - America Ck, White, e  White  Stare, Zip  City or Tov	un Indian, otc.  Sustry  Code)
	To the Hospital or Attending Physician: The law requires that the death certificate be executed To the Hospital or Attending Physician. The law requires that the death of the Verbra state death.  To the Funeral Director: After this certificate has been signed by the attending physician and the completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit of the Proposition of the Proposit	Completed by Physician/Medical Examiner	23a. Part1. Enter the disease, or comshock, or hear failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a cons  Due to (or as a cons  Due to (or as a cons  d. Due to (or as a cons  d. Due to (or as a cons  d. Due to (or as a cons  d. Due to (or as a cons  d. Due to (or as a cons  d. Due to (or as a cons  d. Due to (or as a cons  d. Due to (or as a cons  d. Due to (or as a cons  d. Due to (or as a cons  d. Due to (or as a cons  d. Due to (or as a cons  d. Due to (or as a cons  d. Due to (or as a cons  d. Due to (or as a cons  d. Due to (or as a cons	equence of):  equence of):  equence of):  equence of):  equence of):  equence of):  equence of):  equence of):  equence of):  equence of):	In Fay c	70>		23d. Dat Mo obacco use contr Yes 2) 2 No an 24b. V	te of deliver nth [	Day Year cause of death?
DIVISION OF VICE IN	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours affer death: within 24 hours affer death: or the Funestal Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	edicai Certification: To Be	one) E Medical Exer	28a. Date of Injury (Month, Day Year)	home, farm, sti	of 28c. Injury Mon 1  reet, factory, office h occurred at the tirrivestigation, in my control of the control of	er: 4 Nursing h	ath (Check only of the check o	one)  dence 6 Other how injury occurr  Street and Numb wn, State)  cause(s) and ma date and place, a	er (Specify) ed  er or Rural unner as sta	Route Number, ted. the cause(s)
16	4		30. Name and address of person who William Tan  31. Date filed (Month, Day, Year)	completed cause of death (III	Libe.	Print) Read	e number 14849 1 Eld	ers burg	June MD		

DHMH 17 Rev 1/2001

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of Speeder

ORIGINAL

			State of Maryland / Dep 1- State Amend #10b-f, perFH, g868, 6/25/07 TT Ce	ertificate of Death	Mental Hyو ۶	giene () () 7	20381
П	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Dea Month	ath Day Year	3. Time of Death
	/Medic	_	John Richard Welling		June 22	, 2007	2:30 A. M
	Examir	er	4a. Facility Name (If not institution, give street and number)  Carroll Hospital Center	4b. City, Town, or Location of Deat Westminster	h	4c. County of Deat  Carroll	h
i,	Funeral Director	-	5. Social Security Number 220–16–6807 6. Sex 2 F 7. Age (In yrs. last birthda) 81 Yrs.	y If Under 1 Year If Under 24 Hrs Months Days Hours Min.		y, Year) Co	nplace (State or Foreign untry) <b>y1and</b>
	with the Maryland a or 28s-f show	ctor	Usuat Residence of Decedent  10a. State 10b. County Carroll Maryland Daltimore 10c. City, Town or I	minster			10d. Inside City Limits
	ath with the Maryla 23a or 28a-f shov	al Dire	10e. Street and Number 509 S. Frizzellburg Rd.  231 Chartley Drive	10f. Zip Code 21158	1	10g. Citizen of What Co United Stat	untry? es
9036	ours after der rel', or items Exertiner m	by Funeral Director	11. Marital Status  1  Never Married 2 Married  3XWidowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent Ever in U.S. 13  24. Was Decedent Ever in U.S. 13  25. Was Decedent Ever in U.S. 13  26. Was Decedent Ever in U.S. 13  27. Was Decedent Ever in U.S. 13  28. Was Decedent Ever in U.S. 13  29. Was Decedent Ever in U.S. 13  29. Was Decedent Ever in U.S. 13  20. Was Decedent Ever in U.S. 13  20. Was Decedent Ever in U.S. 13  20. Was Decedent Ever in U.S. 13  20. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes	Specify Yes or No-	Black, White	
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d 21	Hygie ther ther		17. Father's Name (First, Middle, Last)	ountant	me (First Middle	Accounting Maiden Sumame)	g
Maryland	2 should be filled withir and Mental Hygiene. Is marked other than aumatic event, tre Ms	To Be	Charles Welling	Clara L			
	s 1 and 2 should be filed withing Hoalth and Mental Hygiene. Item 27 is marked other than other traumatic event. Item			ing Address (Street and Number or Ri 32 Woodens Lane;			
Baltimore,	Pages 1 and 3 nent of Health int: if item 27 iry or other tr.		20a. Method of Disposition  XXBurial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)	Valley June	Date 26,	20c. Location - City or	
Baltir	permit. Pages Department of Important: If i any injury or 2002.		21. Signature of unufal Septice Licensee	Gardens 200 2 Name and Address of Facility EC 1605 Reisterstown Wings Mills, Mary	khardt. Fr	Timonium, M uneral Chap	
76	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enshook, or heart failure. List only one cause on each line.  tmmediate Cause (Final disease or condition	wings Mills, Mary nier the mode of dying, such as cardial	e or respiratory ari	rest,	Approximate Interval Between Onset and Death
,8760,	Medical Examiner  bhysicien and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	0			
P.O. Box 6	n certif	Completed by Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	very Day Year
	w requires that the death been signed by the ette should be detached for	d by Pi	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		obacco use contribute to es 2 □ No 3 □ Pro	/
al Records,	The la ate has page 2				24a. Was a autop: perfor 1 Yes	sy prior to death?	topsy findings available ompletion of cause of 2 No
Vital	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ DO Hospital: 1 ☐ Inpatient 2 ☐ FR/Outpatient	Other	ath Check only or		
of	Jing After fune	tlon: To	27. Manner Death 1 Latural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)	FIL 3 DOA 4 INUISING F		ence 6 Other (Specow injury occurred	ify)
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attercompletely filled in by the fune.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		28f. Location (S City or Town	treet and Number or Ru n, State)	ral Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dirccompletely filled in	Medical C	29a. Certifier (Check only one)  1	th occurred at the time, date and place ovestigation, in my opinion, death occu	and due to the corred at the time, d	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To the within To the comp	Me	29b. Signature and title of persitier MD	29c. License number  0 - 0 0 5 4 2	18	06-22	Day, Year)
1	27		3 Name and address of person who completed cause of death (Item 23a) (Type DR Kaman B Kaner 349	D-00542 Talcoly alune	West	minites Mo	21177
	Sta Registr		31. Date filed (Month, Day, Year) Registrar's Signature	ale)			

			1 - For State Registrar	State of Ma	aryland / Depa <i>Cel</i>	artmen <i>rtificate</i>			and M	lental H		ene	07	20	382
п	O. Dhysio	ion	1. Decedent's Name (First, Middle, La	st)						2. Date of I	Death	Day	Yeer	3. Time	of Death
	Physici /Medi		Charles Lee Whi	ttington							19	, 2007		7:15	AM M
	Examir	ner										4c. Count	y of Death		
			Broadmead					svill				Bal	ltimo	re	
н	Funeral		5. Social Security Number 6. S	ex 7.Ag ∏M 2☐F	e (In yrs. last birthday)  O / Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of E (Month, L	Day, Y	(ear)	Cou	ntry)	e or Foreign
	Director		213-10-4137 Usual Residence of Decedent	A1	94 Yrs.					Aug 3	, 1	912	Mary	land	<u> </u>
	/land		10a. State 10b. County		10c. City, Town or Lo	cation								10d. Inside	City Limits
	Mar.	to	MD Baltimor	e	Cockeys	ville								1 🗆 Y	es 2√ No
	h the	Funeral Director	10e. Street and Number			10f. Zip	Code				10g	. Citizen of	What Cou	ntry?	
	th will	a D	13801 York Road	B-11				21030				USA			
	ems ems	ner	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S. 13.	Vas Deced				ecify Yes or N Rican, etc.)	10-	14. Ra	ce · Ameri	can Indian,	
92	or h	F	1 Never Married 2 Married	1 ☐ Yes 2 💢 N If Yes, Give	No	l∐ Yes 2		Specify:	i, Fuello	nicari, etc.)			ick, White, fy: whi		
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7	d within 72 ho piene. r than "natu the Medical	Completed	15. Decedent's Ed (Specify only highest gra		16a. Deced	kind of wor.	k done d	urina most	of worki	ng	16	6b. Kind of B	Business/Ir	dustry	unk
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an	Q 22 D 9	To Be	Charles Lee Whit						Suc		0, 7910.	den Sama	110)		
Maryland	2 should be and Menta is marked aumatic ev	-	19a. Informant's Name/Relationship (	Type, Print)	19b. Mailin	g Address	(Street a			l Route Num	ber. C	City or Town	State Zi	Code)	
	nd 2 alth a 27 ts		Carolyn Whittingt	on/spouse						cockeys				1030	
Je,	item othe		20a. Method of Disposition		20b. Place of Dispo- cemetery, cren	sition (Nam	e of	- T		ate	-	c. Location			
Ē	Page nent c nt: If rry or		1 Burial 2 Cremation 3 C 3 Donation 5 Other (Specific		John Blary, Crain	ratory or ou	ner place	" ;							
Baltimore,	permit. Pages Department of I Important: If ite any injury or of		21. Signature	Wade, pir	ector 22	Name and	Addres	s of Facility	Boar	d 655	W.	Balti	more	Stree	o †
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			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  Immediate Cause (Final III Do Complete Consequence of the mode of dying, such as cardiac or respiratory arrest, approximate Interval Between Onset and Death												etween
ŷ.	Physician		Immediate Cause (Final disease or condition resulting in death)	a	ROSEP.	515								Unset and	d Death
	/Medical Examiner		resulting in death)	Due to (or as a	a consequence of):										
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	uted I Insit	Examiner	Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
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Вох	leath certific attending p	an/N	200. Was decedent program	23c. If yes, outcome of		Ectopic pre						23d. Da	te of delive	∍ry	
о. П	the death certifi y the attending p	sicia	in the past 12 months? 1 Yes 2 No	4☐Pregnant at		Other (spe	cify)					Mo	onth	Day	Year
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orc	v requir	ted	DITIOLI	20 100	<u> </u>	/				1	Yes	2 02/No	3 Prob	ably 4 [	]Unknown
Records,	e law has b	Completed	ATRIAL	- F113	KILLA	7/01	$\bigvee$			24a. Wa auto	psy		prior to co	psy finding: mpletion of	s available cause of
		Co	CHF							perf	ormec 2 🕡		death? 1 🗌 Yes	2□ No	
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ō	Phys this ral dii	٦.	1 Yes 2 No	1 ☐ Inpatier 28a. Date of Injury			Contract of the Contract of th	4 Mur	sing Hor			e 6 □Oth		y)	
ou	ding h. After funer	ton	1 ☑Natural 5 ☐ Pending	(Month, Day	Year) Injury	M	c. Injury Work	at ? es 2⊡N		8d. Describe	now	injury occur	reu		
Division	l or Attending after death. Director: After in by the fune	flca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ry · At home, farm, stre				- 1	8f. Location	Stree	t and Numb	er or Rura	l Route Nu	mber
á	al or A after I Direct d in by	Certification;	4 Homicide	building, etc.	. (Specify)	,				City or To				. , , , , , , , , , , , , , , , , , , ,	,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	calc	29a. Certifier 1 Certifying Phy (Check only 2 Medicel Exem	rsicien: To the best of	f my knowledge, death	occurred a	t the time	, date and	place, a	nd due to the	caus	e(s) and ma	nner as s	ated.	
	the Ho iin 24 the Fu	ledical	one)	and manner stat	examination and/or inv	estigation, i	n my opi	nion, death	occurre	at the time	date	and place,	and due to	the cause	(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier		11-11	29c.	License	number			29d.	Date signer	d (Month,	Dey, Year)	
			Barbaro	car	Oll/11	7	DE	583	92			6/1	19/	200	7
			30. Name and address of person who o	ompleted cause of de	ath (Item 23a) (Type, F	4	1	1/	7/1	RD		0	, ,		1115
			31. Date filed (Month, Day, Yeer)	KKULL 30 Panietra	rs Signature	1380	1/	YOK	1/	KD	, (	UCK	EYS	VILL	GMD
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WHITTINGTON, CHARLES

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year Blagden. Н. Wharton 21 2007 /Medical June 2:15PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1014 Green Hill Farm Road Reisterstown Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Months Days Hours Director 219-22-2638 Oct. 10,1925 81 MD Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If tien 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b County 10d. Inside City Limits Director 1 ☐ Yes 2 1 No MD Baltimore Reisterstown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1014 GreenHill Farm Road 21136 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ģ Specify Specify: 3 Widowed 4 NDivorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Banker Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Lawrence Wharton Louise Hazlehurst 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kim Wharton Daughter 1014 Green Hill Farm Road, Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 6/22/07 Carroll Cremation Hampstead, MD 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediate Cause (Final disease or condition resulting in death) **Physician** narrea MUN /Medical Due to ( as a consequence of) Examiner COMman Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 certificate 1☐ Yes the Hospital or Attending Physician; 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 \sum Nursing Home ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 Other (Specify) this 27. Manper of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 2 ☐ Accident (Month, Day 124 hours after death.

16 Funeral Director; A pletely filled in by the fu 1 ☐ Yes 2 □ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) To the within 2. 29b. Signature and title of certifie 30. Name and address of person w N Charles St, Baltmore MD 21212 31. Date filed (Month, Day, Year) Registrar's Signature State JUN 2 5 Registrar 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Kenneth Raymond Archibald 2007 6 6:20  $P_{\bullet}^{M}$ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Richie House Baltimore 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 48 215-66-4433 Director 3/11/1959 Maryland Usual Residence of Decedent 10a. State 10c. City. Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at Maryland Baltimore 1 XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1213 Weldon Ave. 21211 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No "natural", or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 1 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify þ 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Restaurant Manager Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Charles Archibald, Sr. Audrey Lucille Rosier ٥ 19a. Informant's Name/Relationship (Type. Print) Father 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Joseph Charles Archibald, Sr. 3015 Regal Oak Ct., Manchester, Maryland 21102 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If It any injury or conce. 1 ☐Burial 2 X Cremation 3 ☐ Removal from State Carroll Cremation 4 ☐ Donation 5 ☐ Other (Specify) 6/6/2007 Hampstead, Maryland 22. Name and Address of Facility Eline Funeral Home, 934 South 21. Signature of Funeral Service Licenses M01490 Main Street, Hampstead, Maryland 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or is consevu Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine use as the burial-tra Due to (or as a consequence of): physician IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4□Pregnant at time of death signed by the a 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use co bute to the cause of death? Completed by 1 🗌 Yes 3 ☐ Probably 4 Unknown funeral director, page 2 should 24a. Was an Were autopsy findings available autopsy perform 20 25. Was case referred to nedical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 6 🛮 Other (Specify) 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b, Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 D atural 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide

Division or Vital Records, P.O. Box 68760, 10/4/07 Archi bold Jenneth

Baltimore, Maryland 21215-0036

after death. filled in by thin 24 hours a the Funeral D

State

4 🔲 Homicide

29b. Signature and title of certifier

JUN 1 1 2007

29a. Certifier (Check only one)

31. Date filed

Registrar

DHMH 17 Rev 1/2001

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

32 Registra

			1 - For State Registrar	State of I	Maryland /		artment <i>rtificate</i>			ind M		iene g. No.	07	20385
	Physici /Medi		Decedent's Name (First, Middle, La	Altmar	\						2. Date of Deat Month June	Day	Year 2007	3. Time of Death 9:35 pM
	Examir		4a. Facility Name (If not institution, given	e street and numb	er)		4b. City, 1	Town, or L	ocation o	f Death		4c. Coun	ty of Death	
			Holy Cross Rehab and	Nursing Cer	iter		5	Silver	Spri	ng		Mot	ntgomer	У
	Funeral Director			Sex 7. 1 1 2 M 2 □ F			y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.				8. Date of Birth (Month, Day, August 2,	Year) Country)		**
	pu		Usual Residence of Decedent  10a. State 10b. County		10c. City, To									0.4 1
	sho sho	5			100. Oily, 100									10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	he N	Director		omery			Silver		g			2-011	(1)(5-1-0	
	with a or		10e. Street and Number				10f. Zip				"	og. Citizen o		ntry ?
	eath	era	2201 Colston D	12. Was Decede	et Ever in II C	12	Mas Daged		0910	in? /Cna	andry Voc or No		.S.A. ace · Americ	can Indian
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23e or 28e-f show or other traumatic event, the Micdical Examinar roust be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	Amed Force 1 Tyes 2 If Yes, Give Year or Date	os? □ No		was Decedor If Yes, speci 1 ☐ Yes 2	fy Cuban,	Mexican, Specify:	Puerto	ecify Yes or No- Rican, etc.)		ack, White,	
Ŏ	2 ho	Completed	15. Decedent's E		168		dent's Usual			-/		6b. Kind of		
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7	gien.	Com		4		В	usiness	sman				Self I	Employe	đ
פ	a Hy a Hy Loth	Be (	17. Father's Name (First, Middle, Last	)				1	8. Mother	r's Name	(First, Middle, N	taiden Suma	ame)	
<u>a</u>	Ments Ments priked	70	Samuel Altma	n					1	Anna	Scheiner			
al	and l	ľ	19a. Informant's Name/Relationship (	Type, Print)	19	b. Mailir	ng Address	(Street an	d Numbe	r or Rura	i Route Number,	City or Tow	n, State, Zip	Code)
Σ.	and alth		Stephen Altman -	Son		9304	Winbou	rne R	oad, I	Burke	, Virginia	2201	5	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra ance.		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Speci		110	ery, crei	sition (Nam matory or oti n Cemete	her place)				20c. Location Ade1phi	0.01	
alt:	Dartm Sorts	- 1	21. Signature of Frineral Service Live		iic. iic	1	. Name and		of Facility		2007	ndcipni	,	and
m	P P P G		Janey 1	Thrui		H	ines-Ri 1800 Ne	naldi w Ham	Funer oshi re	ral H	ome, Inc. nue. Silve	r Sprii	ng. Mar	yland 20904
	Physician /Medical Examiner	ner	23a. Part. Enter the disease or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter chaptering	a. Dem Due to (or	\	of):	er the mode	of dying,	such as o	cardiac o	r respiratory arre	st,		Approximate Interval Between Onset and Death
Box 68760,	eath certificate be executed ettending physicien and for use as the burial-transit	Physician/Medical Examiner	cause. Entire underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant	d23c. If yes, outcor	as a consequence	-	Ectopic pre	omaney					ate of delive	,
o.	that the death led by the ette detached for	hysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		at time of death		Other (spe						fonth	Day Year
rds, P	law requires that the death certific as been signed by the ettending F 2 should be detached for use as	ed by P	Part II. Other significant conditions of Coronary Artery	Disease	n but not resulting	in the u	nderlying ca	use given	in Part I.					ne cause of death?
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Ħ	ician: Th certificete ector, pag	Be	25. Was case referred to medical examiner?					2	26. Place	of Death	(Check only one	)		
Division of Vital Records,	Jing Ph J. After th funeral	은	1 ☐ Yes 2 ☐ No  27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio			utpatier Time of Injury		c. Injury a Work?	4 🖭 NUI	2	ne 5 Reside 28d. Describe ho			y)
Divisi	5 # in ⊆	Certification;	3 Suicide 6 Could not be determined	e 28e. Place of	Injury · At home, f etc. (Specify)	arm, str	eet, factory,	office		2	28f. Location (Str City or Town	eet and Nun State)	nber or Rura	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	Medical	29a. Certifier 1 Certifying Pt (Check only one)	nysicien: To the be miner: On the basis and manner	s of examination a	e, death	occurred a vestigation,	t the time, in my opin	date and tion, deatl	l place, a	and due to the ca ed at the time, da	use(s) and r te and place	nanner as s , and due to	tated. o the cause(s)
	withir To th	ž	29b. Signature and title of certifier				29c.	License r	number		29	d. Date sign	ed (Month,	Day, Year)
3			S wtterow	Depon mi	0		7	0005	333	F		6/6	107	
1	-		30. Name and address of perso who	completed cause of	f death (Item 23a)	(Туре	,		,	-		- 10		
			25 Main Street	Rei	1	υΛ.	Mac	ylan	1.6	Oroti	hy Seay, M	I.D.		
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			1 - For State Registrar	State of M	aryland	-	artmen tificate			Mental Hy	/gien Reg. N	6 0 1	20386	
	21		1. Decedent's Name (First, Middle, L	ast)						2. Date of D		ay Year	3. Time of Death	
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	Examin		4a. Facility Name (If not institution, ga	ive street and number)			4b. City, Town, or Location of Death			h	4	c. County of Dea	th	
			5 Punte Lar						Essex			Balti	more	
	Funeral		5. Social Security Number 6.	Sex 7. Ag	e (In yrs. la:	**	tf Under Months		If Under 24 Hrs Hours Min.		ay, Yea.	9. Bir Co	thplace (State or Foreign ountry)	
	Director		210-74-7130	WO M ZUF	52	Yrs.	4/17/			195		laryland		
	and *		Usual Residence of Decedent  10a. State 10b. County		10c, City	Town or Lo	cation						10d. tnside City Limits	
	Aaryl sho	ō	MD. Balti	more					Baltin	070			1 ☐ Yes 2 🛣 No	
	28s-	ect	10e. Street and Number	THOT C			10f. Zip	Code	Date	101.6	10a C	Citizen of What Country?		
	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or Items 23a or 28s-1 show that the Medical Examinat must be rediffed at	Funeral Director	5 Punte Lar	ne.					21221				States	
	me 2:	era	11. Marital Status	12. Was Decedent	Ever in U.S.	. 13. \	Vas Deced			anic Origin? (Specify Yes or No- Mexican, Puerto Rican, etc.)		14. Race - Ame		
ယ	or Iter	표	1 ☐ Never Married 2 Married	Armed Forces?	No				n, Mexican, Puer	to Rican, etc.)		Black, Whit	e, etc.	
9	ours a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			I□Yes 2	2LXNo	Specify:			Specify:	hite	
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	ygier ygier t,	ပ်	12	0		Corr	ecti		l Offi				e County	
<u>n</u>	d off	Be	17. Father's Name (First, Middle, Las	t)					18. Mother's Na		e, Maide	n Sumame)		
Maryland	ould Mer Marke	2	Samuel	_		Biar				ela			Nido	
<u>a</u>	l 2 st		19a. Informant's Name/Relationship		0 \								Zip Code) 21084	
	t and Heelt mm 2: ther t		Sharon M. Bia 20a. Method of Disposition	inca (Wi	fe)	ce of Dispo			Drive	Jarr Date		SVILLE Location - City or		
ŏ	or or		1 Burial 2 Cremation 3		cen	netery, cren	natory or o	ther place						
altimore,	rt. Partmer		4 Donation 5 Other (Spec	A-7	Cari	roll						ampstea		
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mentat Hygiene. Importent: If Item 27 le market other than "naturel", or Items 23a or 28a-f ahow apprintury or other treumatic event, The Medical Examinat must be notified at ORCE.		21. Signature of Funeral Service Lice		Ti-	-			s of Facility	Jarret	tsv:	ille, N	Maryland	
			23a Part Enter the disease or cor	nnlications that caused	t the death							al Home	P.A. Approximate	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	1.1		1	, I		· _   .	o or respiretory	os.,	`	Interval Between Onset and Death	
	Physician /Medical:		disease or condition resulting in death)	a Hypertan			1050	eyoti	c (andi	ovascul	ir L	) iseas e		
	Examiner			Due to (or as	a conseque	nce of):								
	*	e e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a conseque	a consequence of):								
NP	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
o O	exec an an rial-tr	Exa	resulting in death) Last	Due to (or as	a conseque	nce of):								
68760,	ificate be executed g physician and as the burial-transit	edicai		d										
	ng ph as th	Med	IF FEMALE:			_								
Вох	eath certil ettending for use a	an/	23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pre	egnancy				23d. Date of de		
H	e dea	Sici	in the past 12 months? 1 Yes 2 No	4☐Pregnant at 9☐ Unknown			Other (spe					Month	Day Year	
о. О	res thet the death cer igned by the ettendin be detached for use	Physician/M	9 Unknown							00.00				
ŝ	The law requires thet the death certifies the been signed by the ettending page 2 should be detached for use a	þ	Part If. Other significant conditions	contributing to death b	ut not resum	ing in the ur	ideriying ca	ause give	n in Part t.		Yes :		the cause of death?	
5	w requir been si should	eted						-		'	195	2 LINU 3 LIF	ODADIY 4 HOTIKITOWIS	
Şeç	elaw hasb je2s	Completed								24a. Wa:	psy	prior to	topsy findings available completion of cause of	
<u>=</u>	ysicien: The is certificate hi director, page									1 ☐ Yes	ormed? 2 N	death?	2 🗆 No	
Ë	ricien: Th certificate rector, pag	Be	25. Was case referred to medicat examiner?	Hospitat				Othe	26. Ptace of De	1.7				
ō	Phys this ral dii	5	1 Yes 2 No 27. Manner of Death	1 inpatie		VOutpatien 8b. Time of		A	4   Nursing F	10me 5 Res 28d. Describe		6 □Other (Spe	cify)	
5	ding h. After fune	ion	1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	Injury	· M	8c. Injury Work	? ′es 2 ∐No	200. Describe	III WOII	ary occurred		
Division of Vital Records,	deat ctor: y the	fica	3 Suicide 6 Could not	be Oga Othan of the	ury - At hom	e. farm. stre				28f. Location	(Street a	and Number or Ri	ural Route Number,	
2	aftar aftar Olred d in b	Certification:	4  Homicide determined	building, et	c. (Specify)			,		City or To	wn, Sta	te)		
	spite nours nerel		29a. Certifier 1 Certifying P	hysicien: To the best	of my knowle	edge, death	occurred a	at the time	e, date and place	and due to the	cause(	s) and manner as	stated.	
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical Exe	miner: On the basis o and manner st	f examination ated.	n and/or inv	estigation,	in my op	inion, death occi	irred at the time	, date ar	nd place, and due	to the cause(s)	
	To the Hospital or Attending Physicien: within 42 4 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, p	ž	29b. Signature and title of centrier	100	١		29c	License	number		29d. D	ate signed (Mont	h, Day, Year)	
			1 Hittle N	72 Vet	utu		1	)/0	5667		Ju	ne 20	2007	
	15		30. Name and address of person who	11 8. 1	eath (Item 2	3a) (Type, I	Print)	110	١ . د سيم	) ,(1	-	\ <u> </u>		
				3 Registr	ar's Signatur	ambl	6 H;	110	1, 44+	herv:11	e, '	Mg S	1043	
	Sta Registr	_	31. Date filed (Month, Day, Year)	107 Este	ar's Signatur	Goo	The state of the s							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1:05 A M Ray Edward Bailey 9 2007 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days 213-56-0687 57 June 9, 1950 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ns 23a or 28a-f show must be notified at Greenbelt 1X Yes 2 No Director MD Prince George's s 1 and 2 should be filed within 72 hours after death with the I Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-other traumatic event, the Medical Examiner must be notifi 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20770 USA 2H Southway Funeral tal Hygiene. d other than "natural", or items 2? event, the Medical Examiner mus 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Greenbelt Service Elementary/Secondary (0-12) College (1-4or 5+) Auto Mechanic Center 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked, any injury or other traumatic evone. Shirley Gray Raymond S. Bailey 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2H Southway, Greenbelt, Maryland Christine Bailey-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ft. Lincoln Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 13 Burial 2 ☐ Cremation 3 ☐ Removal from State 6/13/07 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 4739 Baltimore Avenue 21. Sign June 1 Fineral Service Lionniee 22. Name and Address of Facility 73 Gasch's Funeral Home Hyattsville, MD 20781 Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final carcinoma of pancreas **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Understrip Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1□Yes 2□No Division or Vital Records, P.O. 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4XJUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA Inpatient Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After I or Attending F after death. 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0052586 6/10/07 Patel Jayanti 20910 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Holy Cross Hospital, 1500 Forest Glen Road, Silver Spring, MD Patel Jayanti 32. Registrar's Signat 31. Date filed (Month, Day, Year) JUN 1 1 2007 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Baker William D. 2007 5:30 A<sup>M</sup> June 11, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick Northampton Manor If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 XM 2 □ F Months Days Hours March 14, 1910 Maryland 97 Director 213-16-1537 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State r 28a-f show notified at 1 XIYes 2 □ No Director Frederick Maryland Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or must be r United States 21701 200 East 16th Street Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ≥ Z No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Examiner 1 ☐ Never Married 2 ☐ Married 6 Specify: White 1 ☐ Yes 2 X No Specify: ş 3 Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Ith and Mental Hygiene.
27 Is marked other than "I r traumatic event, the Med College (1-4or 5+) Elementary/Secondary (0-12) Dairy 6 Farmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John D. Baker Nellie Cramer ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 Is any injury or other trau 200 Chapel Court, Unit 214, Walkersville, MD 21793 Doris Harbaugh / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 6/11/2007 Walkersville, Maryland Glade Cemetery 4 Donation 5 Dother (Specify) permit. 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee 40 Fulton Ave., Walkersville, MD 21793 23a Part. Enter the fligease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 5 DAYS **Physician** PNEUMONIA ASPIRATION /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated worth. Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Year in the past 12 months? Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes ALZHOMERS DEMENTIA Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an OSTEGARTURITIS autopsy performed 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 100 1 Inpatient 2 ER/Outpatient 3 DOA P 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) Injury 5 ☐ Pending investigation 1 Natural 1 □ Yes 2 □ No I Director: / d in by the f 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours at To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marrier stated. 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifie

State Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760.

RICURD

31. Date filed (Monty UN Yar) 2 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JELA

MD

4.600

PO BOX

D32171

WALKERSUILLE

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Giaic	JI IVIQ			ificate of		Workari	Reg. N	.2007	20389	
	Physicia	an	1. Decedent's Name (First, Middle				2. Date of Month	D	ay Year	3. Time of Death				
	/Medic		Mildred Brelic									2007	5:58 P M	
	Examin	er	4a. Facility Name (If not institution			1 + b		4b. City, Town, or		ath	44	4c. County of Death  Frederick		
			Golden Living / 5. Social Security Number	6. Sex		(In yrs. last birt	hdav)	If Under 1 Year	ederick   If Under 24 Hi		Birth	9. Birt	hplace (State or Foreign	
	Funeral Director		718-18-7402	1□M 2⊠F			Yrs.	Months Days	Hours Min	n. (Month, May 2	Day, Year 4, 19			
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location									10d. Inside City Limits		
	Maryl 1 sho led a	Ď	Maryland Frede	rick		Fra	der	i ale					1 ☑Yes 2 ☐ No	
	r 28a	irec	10e. Street and Number	LICK		TIC	uer	10f. Zip Code			10g. C	itizen of What Co	ountry?	
	th with	Funeral Directo	30 North Place					217	701			United	l States	
	r dea	ner	11. Marital Status	12. Was Dec Armed F	orces?		13. W	as Decedent of H Yes, specify Cuba	ispanic Origin? an, Mexican, Pu	(Specify Yes or erto Rican, etc.)	No-	14. Race - Ame Black, Whit		
030	be flied within 72 hours after death with the Maryland Hygiene.  4 other than "natural" or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1  Never Married 2  Marri 3  Widowed 4  Divorced	ed 1 ☐ Yes If Yes, G Year or I	2 <b>½₹</b> No ive ⊃ates:	0	1	☐ Yes 2√√ No	2 № No Specify: Sp			Specify: Who	Specify: White	
2-0036	72 hol "natura dical E	Completed	15. Decedent's Education (Specify only highest grade completed) (Sive kind of work done during most of workin life. DO NOT use retired)							orking	16b.	Kind of Business/	'Industry	
1717	within ene. than '	ldmo	Elementary/Secondary (0-12) College (1-4or 5+)  12 College (1-4or 5+)  Grants Technical Assist							F	ederal G	overnment		
0	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Me	Be Co	17. Father's Name (First, Middle,	 Last)						ame (First, Mid			O V O L I I I I I I I I I I I I I I I I I I	
yland	ould be t Mental I arked of atic eve	To B	William R. Henr	у					Alva Co	ok				
E E	2 should I and Men Is marker aumatic		19a. Informant's Name/Relations			- 1	_	•				or Town, State, 2	Zip Code)	
a.` ≥	s 1 and 2 should if Health and Mer Item 27 Is marke other traumatic		0	/ Daughte	er									
Baltimore	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra once.		20a. Method of Disposition    20b. Place of Disposition (Name of cemetery, crematory or other place)   3   Removal from State   3   20c. Location - 1   3   3   3   3   3   3   3   3   3										Maryland	
Ball	permit. Departi Import any inj once,		21. Signature of Funer   Service	Licensee	Skko	ot Cody	11 11 21	Name and Addre Mothy A. 4 South	ss of Facility Berkeb Juliana	ile Fur	eral Sedfo	Home, I rd, PA 1	nc. 5522	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that									Approximate Interval Between	
	Physician		Immediate Cause (Fi	Demer									Onset and Death 2+ years	
	/Medical		resulting in death)	a		consequence of	of):						<u> </u>	
	Examiner	L	Sequentially list conditions,	b	(		-6).							
	ted sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discass or injury that initiated events	Due to	o (or as a	consequence of	ot):					22		
	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to	o (or as a	consequence of	of):							
08/PO	e be e	ledical E		d										
Q	rtificat ng phy as th													
.C. Box	the death certificate be executed y the attending physician and ched for use as the burial-transit	Physician/	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☒ No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)								23d. Date of delivery Month Day Year			
7	that the the the the the the the the the th		Part II. Other significant condition	ons contributing to	death bu	t not resulting in	the un	derlying cause giv	en in Part I.	23e. E	oid tobacco	o use contribute to	o the cause of death?	
202	w requires that the de been signed by the should be detached	d by	Breast Cancer							_   1	☐ Yes	2 <b>XX</b> No 3 □ P	robably 4 □Unknown	
Hecords,	has ye 2	Completed								– a	Vas an utopsy erformed?	24b. Were a prior to death?	utopsy findings available completion of cause of	
	i <b>lcian:</b> Th certificate ector, pag	BeC	25. Was case referred to medical						26. Place of D	Death (Check of	es 🌇 🏗 nly one)	10 10168	2 10	
or <	Physician: this certific ral director,	To E	examiner? 1 ☐ Yes 2 2 No	Hospital: 1	] Inpatier	nt 2□ER/Ou	tpatient		4XX Nursing	Home 5□F	Residence	6 □Other (Spe	ecify)	
			27. Manner of Death 1 XNatural 5 ☐ Pendin	9	e of Injury Inth, Day		Time of njury	28c. Inju		28d. Descr	ibe how in	jury occurred		
<u>s</u>	Attending r death. ector; After by the fune	cati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	not be	o of iniu	ny . At home fa	rm etro	M   1 □ et, factory, office	Yes 2 □ No	28f Locatio	n /Ctmat	and Number or P	ural Route Number,	
DIVISION	al or Attend after death Director; d in by the f	Certification:	4 ☐ Homicide determ	ined 200. Flac	ding, etc.	(Specify)	mi, 300	et, lactory, office		City of	Town, Sta	ario i vuriber or n ate)	arai noute Namber,	
	To the Hospital or within 24 hours after To the Funeral Direct completely filled in the state of	Medical C		g Physician: To the Examiner: On the and ma		examination an								
	To th within To th comp	Me	29b. Signature and title of certifie			-		29c. Licens	se number	* *************************************	29d. E	Date signed (Mon	th, Day, Year)	
	0					>1		D 006	0417		6,	/8/2007		
	10		30. Name and address of person Hemen Shah, M.D	. 65 C Th	omas	Johnso	on D	r., Fred	lerick,	MD 2170	2			
I	Sta Registi		31. Date filed (Month, Day, Year)	2007	egistra	r's Signature	do	ente						

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			1 - State of Maryland State of Maryland		artment o			iene <sub>eg. No.</sub> 0 0	7 20390
	Physici	an	1. Decedent's Name (First, Middle, Last)  Kathleen Tull Burton				2. Date of Deat June 8	Day W	3. Time of Death
9	/Medio Examin		4a. Facility Name (If not institution, give street and number) Atlantic General Hospital		4b. City, Tow Berl	m, or Location of Death	ounc o	4c. County of I	Death
	Funeral Director		5. Social Security Number  215-30-9064  6. Sex 1 M 2 7. Age (In yrs. li	ast birthday) Yrs.	Months Da	ear If Under 24 Hrs. ays Hours Min.	8. Date of Birth (Month, Day, Dec.6,	Year) 9.	Birthplace (State or Foreign Country)
	death with the Maryland ms 23a or 28a-f show rmat be notified at	ctor	10a. State 10b. County 10c. City GA Lumpkin Da			10d. Inside City Limits 1 📉 Yes 2 🗌 No			
	a or 2	Dire	716 Crooked Creek Dr.		10f. Zip Cod	<sup>16</sup> 533	1	0g. Citizen of Wha	it Country?
036	urs after death al', or items 2	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Notice Widowed 4 Divorced  12. Was Decedent Ever in U.S Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	1		of Hispanic Origin? (Sp Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Black, V	American Indian, White, etc. White
Baltimore, Maryland 21215-0036	should be filled within 72 hours after nd Mental Hygiene. I marked other then "natural", or Ite Jarlic avent, the Medical Exam	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give life.	dent's Usual Oc kind of work do DO NOT use re	one during most of work stired)	ing	16b. Kind of Busin	ess/Industry
land 2	s 1 and 2 should be filed with if Heelth and Mental Hygiene. Itam 27 is marked other than other traumatic avent, trans	To Be Co	17. Father's Name (First, Middle, Last)  Ina R. Tull		1001 100	18. Mother's Nam			
Mary	12 shound N and N I ama		19a. Informant's Name/Relationship (Type, Print)	[-		reet and Number or Run			
more, I			1 Burial 2 1 Cremation 3 Removal from State	ace of Dispo emetery, crei	Crooked  osition (Name of matory or other  lopen Ci	place)	Date	ega, GA 3 20c. Location - Cit Frankford	y or Town, State
Baltii	permit. Page Depertment Important: If any Injury o		21. Signatur of Funeral Service Licensee	23	2. Name and Ad	ddress of Facility Th	e Burbag	je Funera	1 Home
•	Physician /Medical Examiner	ner	23a. Pagh. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ence of):					Approximate Interval Between Onset and Death
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ους /2 Τους (- 1.0. Βοχ 6	thet the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetel 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	□Ectopic pregna □ Other (specify			23d. Date o Month	f delivery Day Year
cords, P	sign d be	þ	Part II. Other significant conditions contributing to death but not resu	Iting in the u	inderlying cause	given in Part I.		_	te to the cause of death?
Be &	The law ate has b page 2 si	Completed					24a. Was a autops perform	y prio	
S S S		o Be	25. Was case referred to medical examiner?  1 □ Yes 2 □ No  Hospital: Inpatient 2 □ E	ER/Outpatier	nt 3 DOA	26. Place of Deat Other: 4 ☐ Nursing Ho		e/ ence 6 ⊟Other (	Specify)
Hathler A	ding After fune	Certification; T	t Natural 5 Pending (Month, Day Year)  2 Accident investigation  3 Suicide 6 Could not be 28e. Place of Injury - At hol	28b. Time o Injury me. farm. sti	М	Work? 1 □ Yes 2 □ No		w injury occurred	or Rural Route Number.
Z S	Hospital or A		29a. Certifying Physician: To the best of my know	vledge, deat	h occurred at th	e time, date and place,	City or Town	n, State) ause(s) and manne	er as stated.
	To the Hospitel or Attent within 24 hours after deat To the Funeral Director: completely filled in by the	Medicai	(Check only one)  2 Medical Examiner: On the basis of examination and manner stated.  29b. Signature anglittle of certifier	on and/or in	29c. Lic	cense number		ate and place, and  9d. Date signed (A	
	ET 5 Sta Registr		3. Name and address of person who completed cause of death (Item Victibles Britishing)  31. Date filed (Month, Day, Year)  32. Registrar's Signat	1709	Drint)	2876°	, Tem	ct Tole	0 > ~{ De 19944

			State of Mar	-				lental H	ygier	ne		
			State Registrar		Cer	tificate of L	Death		Reg. I	No.	17	20391
	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of D Month		Day	Year	3. Time of Death
	/Medic			. Sr.	Mir	iam Regir		June	6,	2007		10:45 a M
	Examin	er	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or	Location of Death		'	4c. County	of Death	
			4910 Strathmore Avenue  5. Social Security Number 6. Sex 7. Age	'In yrs. last bir	thday)	Kensingt If Under 1 Year	on If Under 24 Hrs.	8. Date of E	Rirth	M	ont go	omery place (State or Foreign
	Funeral Director		1 □ M 2 □ F		Yrs.	Months Days	Hours Min.	(Month, L	Day, Yea		Coui	ntry)
			577-30-0096 Susual Residence of Decedent	30				Oct.	8, .	1926	Mary	/land
	yland		10a. State 10b. County	0c. City, Town	n or Lo	cation						10d. Inside City Limits
	e Mar a-f sl	cto	Maryland Montgomery	K	ens	ington						1 ☐ Yes 2 🛣 No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g.	Citizen of \	What Cou	ntry?
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at		4910 Strathmore Avenue		-		0895			USA		
	tems	Funeral	11. Marital Status  12. Was Decedent Ev Armed Forces?		13. \	Vas Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp ın, Mexican, Puerto	ecify Yes or I Rican, etc.)	No-		e - Americ ck, White,	can Indian, etc.
30	s afte	by F	1 Never Married 2 Married 1 Yes 2 Nacried 1 Yes, Give 1 Year or Dates:			∏Yes 21X No	Specify:			Specify	/: Whi	ite
3	hour tural al Ex		15. Decedent's Education	16a	Dece	lent's Usual Occup	ation		16b	Kind of B	usiness/In	dustry
Ċ	in 72 n "na Medio	plet	(Specify only highest grade completed)		(Give life. L	kind of work done o OO NOT use retired	during most of work )	ing				,
7	with jiene r thai	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		Те	acher/Pri	incipal		Re]	ligio	us Ed	ducation
ğ	be filed within 72 hours after death with the Marylar tital Hygiene.  d other than "natural", or items 23a or 28a-f show other than medical Examiner must be notified at	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Midd	le, Maio	len Surnan	ne)	
<u>a</u>	should be filed and Mental Hygi s marked other umatic event, t	70 E	Cornelius Brosnan				Mary She	ehan				
Maryiand 21215-0036	2 sho and h is ma rauma		19a. Informant's Name/Relationship (Type, Print) -Religious Sur	19b	. Mailir	g Address (Street a	and Number or Rui	ral Route Nun	nber, Cit	ty or Town,	State, Zij	o Code)
	ages 1 and 2 should b nt of Health and Ment : If item 27 Is marked or other traumatic e		Marian Daniel, C.S.C		49	10 Strath						
aitimore,	ges 1 t of H <sub>t</sub> If iter or oth		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemete	ry, crer	sition (Name of natory or other plac	e) .Tii	<sup>Date</sup> ne 11		. Location -	City or T	own, State
Ě	Pages ment of ant: If its ury or o		4 □ Donation 5 □ Other (Specify)	Gate o	f H	eaven Cen	netery	2007		lver	Sprin	ng, Marylan
na Pa	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Alcensee		F	rancis Addres	S Collins	Funer	al E	Home :	Inc.	
_	90 E 8 9		you & scello			00 Univer				er S	oring	
			23a. Part. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line	e death. Do i	not ent	er the mode of dyin	g, such as cardiac	or respiratory	arrest,			Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)  Metastati	c Mela	nom	a						
	/Medical Examiner		Due to (or as a	consequence	of):							
		<u>~</u>	Sequentially list conditions, if any leading to immediate b. Due to (or as a	consequence	of):						_	
	rted nsit	Ë	Cause (Disease or injury		/-							
<u>,</u>	execun and lal-tra	Examiner	that initiated events resulting in death) Last C Due to (or as a	consequence	of):							
2/90	icate be executed physician and sthe burial-transit	dical	d									
٥	tificat g phy as th	a)								1		
O. Box	The law requires that the death certific te has been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1□Live birth 2		3.	Ectopic pregnancy				1	te of deliv	•
n n	deal	sicis	1 ☐ Yes 2 No 4 ☐ Pregnant at ti			Other (specify)			-	Mo	onth	Day Year
л Э	res that the de signed by the a be detached t	چ ک	9 Li Onknown					T				
Vital Records, P.	es th igned be de	by F	Part II. Other significant conditions contributing to death but	not resulting in	n the u	nderlying cause give	en in Part I.					the cause of death?
00	w require been sign should b	ted						1	_ res	2 X NO	3   PIO	bably 4 ☐Unknown
Ö	las b	lple						24a. Wa au	topsy		prior to co	opsy findings available ompletion of cause of
<u> </u>	: The cate I	Completed						pe 1□ Yes	rformed 2 💃		de <i>a</i> th? 1 ☐ Yes	2 □ No
<u> </u>	ician certifi ector	Be	25. Was case referred to medical examiner?  Hospital: Hospital:			Oth	26. Place of Dear	th (Check onl)	one)			
0	Physician: The lar this certificate has ral director, page 2	은	1 ☐ Yes 2 ☐ XNo	2   ER/Ou	utpatien Time of		TE Horsing II					fy)
	ding h h. After funer	ion	1 ☑Natural 5 ☐ Pending (Month, Day		Injury	Worl	Yes 2 □ No	28d. Describ	e now ii	rijury occur	reu	
S	or Attendater death Director: in by the	icat	3 Suicide 6 Could not be 28e. Place of injur	/ - At home, fa	rm, str			28f. Location	(Street	t and Numl	per or Run	al Route Number,
DIVISION OF	after Dire	Certification:	4 Homicide determined building, etc.	(Specify)				City or 7				,
_	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, it is a second to the funeral director.		29a. Certifier 1 Certifying Physician: To the best of									
	n 24 ł n 24 ł ie Fui	edical	(Check only one) 2 ☐ Medical Examiner: On the basis of earth manner state		nd/or in	vestigation, in my o	pinion, death occu	rred at the tim	e, date	and place,	and due	to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifler			29c. Licens						Day, Year)
)	1		Several a Hechenous , M.D.				05373		J	une 8	3, 20	07
•	5		30. Name and address of person who completed cause of dea Bernard A. Heckman, M.D.			Print) ron Stree	t, Silve	r Spri	ng,	MD 20	910	
	Sta Registr		31. Date filed (Month, Day, Year)  JUN 11 2007  32 Flegistrar	s Signature	A	anti)						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 7020 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** June 5, 2007 4:35A. Brook /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6629 Whitegate Road Clarksville Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth May 6,1907 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 🔀 F 577-52-6375 100 England Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Clarksville Maryland Howard 1 ☐ Yes 2 No 7 is marked other than "natural", or items 23a or 28a-f si traumatic event, the Medical Examiner must be notified Director 10e. Street and Number 10f. Zip Code 21029 10g. Citizen of What Country? United States 6629 Whitegate Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hedwig Rietz Jerald Percy Brook 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is n any injury or other traum once. 6703 Whitegate Road Clarksville, Maryland 21029 Joeann E. Townsend -friend 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 6/7/2007 Alexandria, Virginia 4 Donation 5 Dother (Specify) 21. Signature of Faneral Service/Licentee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter lie disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dementia 10 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed signed by the attending physician and I be detached for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12-months? 1 ☐ Yes 24 No Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown Colon Cancer Completed 24b. Were autopsy findings available prior to completion of cause of autopsy Be Certification:

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director. p

					1 Yes 2 ZNo	1 Yes 2 No							
25. Was case refer	red to medical		26. Place of Death (Check only one)										
examiner? 1 ☐ Yes 2 ☐	<b>N</b> o	Hospital: 1   Inpatient 2   ER/O	Outpatient 3 DOA	Home 5 X Residence 6 □Other (Specify)									
27. Manner of Deat 14 Natural 2 ☐ Accident	5 ☐ Pending investigation	(Month, Day Year)	Time of 280 Injury M	c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury oc	courred							
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injury - At home, for building, etc. (Specify)	arm, street, factory, o	office	28f. Location (Street and No City or Town, State)	umber or Rural Route Number,							
29a. Certifier (Check only one)		nysician: To the best of my knowledg niner: On the basis of examination a and manner stated.											

29b. Signature and title

29c. License number

29d. Date signed (Month, Day, Year)

June 5, 2007

30. Name and address of person who ed cause of death (Item 23a) (Type, Print)

Peter Cheng, M.D. Knoll North Drive, #260 Columbia, Maryland 21045

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene & 19B PER FH 06-13-2007
Registrar Registrar Registrar Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 9<sup>Day</sup> **Physician** 200<sup>Y</sup>7 JŬÑE 5:45 AM MICHAEL ANTHONY CHIRIGOS, SR. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY BETHESDA SUBURBAN HOSPITAL 8. Date of Birth (Month Pay Year) SEPT 14 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min 1**X** M 2□ F 82 1924 Yrs. 219-16-2680 Director WV Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. Count 28a-f show MONTGOMERY MD POTOMAC 1 ☐ Yes 2 M No ns 23a or 28a-f sh must be notified Director 4 COLD STREAM CT. 4 COLD SPRING CT. 10g. Citizen of What Country? 10e Street and Number USA items 23a Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Nyes 2 No 1943 − If Yes, Give Year or Dates: 1946 Black, White, etc. Pages 1 and 2 should be filed within 72 hours after d nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or iter ury or other traumatic event, the Medical Examiner. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 M No Specify: WHITE ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) HEALTH CARE RESEARCH SCIENTIST 5+ 18. Mother's Name (First, Middle, Maiden Surname)
MARY MICHAELIS 17. Father's Name (First, Middle, Last) Be ANTHONY CHIRIGOS ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

DOTOMAC, MD 20854 19a. Informant's Name/Relationship (Type. Print) COLD STREAM CT., POTOMAC, MD 4 COLD SPRING CT. MARY CHIRIGOS / SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place)
STAUFFER CREMATORY 6/12/07 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o 1 ☐ Burial 2 Cremation 3 ☐ Removal from State FREDERICK, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
HILTON FUNERAL HOME 20838 P.O. BOX 86, BARNESVILLE, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MINUTES Physician ACUTE MYOCARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY ATHEROSCLEROSIS YEARS Esquantiany list continuous, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine that initiated events resulting in death) Last and Due to (or as a consequence of) hision or Vital Records, P.O. Box 68760, The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Year Month Day 4□Pregnant at time of death 9□Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? hirigos, Michael 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Registrar

10/6/01

29b. Signature and

29c. License number

29d. Date signed (Month, Day, Year)

20815

and manner stated.

Mame and address of person who completed cause of death (Item 23a) (Type, Print)

2,2007

State Registrar 31. Date filed (Month, Day, Year) 2007 JUN 12

Hei

29b. Signature and title of certifier

Dale



NS

Frederick

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21703

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** P. M Kathleen Ann Colvin 8:07 2007 /Medical 6 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 2438 Fairway Oaks Court Carroll Hamostead 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 T F 217-50-7790 Director 60 1/5/1947 Ohio Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits show r 28a-f shov notified at 1 ☐ Yes 2 XNo Directo Maryland Carroll Hampstead 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ral", or Items 23a or Examiner must be r 2438 Fairway Oaks Court 21074 United States Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural". 77 Is marked other than "nature traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ralph P. Noltemeyer Sarah Bowers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a :: If item 27 Is vor other tra 2438 Fairway Oaks Court Hampstead, Maryland 21074 Ralph R. Colvin - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Important: If any Injury or 4 □ Donation 5 □ Other (Specify) Carroll Cremation 6/6/2007 Hampstead, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eline Funeral Home, 934 South M01490 Main Street Hampstead Maryland 21074 23a. Part - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** metastalle 20 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical attending properties of the pr IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Day Year 5 Other (specify) ed by the a detached f 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has t irector, page 2 s autopsy perform 1□ Yes 2☑No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. D Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ို 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

-was

State Registrar Thon Berkman mo 2401 West Belvedere Avive, Balthoure, May lad 21215

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUN 0

7 2007 Color & Sanature

17. Father's Name (First, Middle, Last)

ဂ

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

**Physician** 

/Medical

**Examiner** 

burial-transi

attending physician

Division or Vital Records, P.O. Box 68760

Rosa Durruthy

Higinio Durruthy 19a. Informant's Name/Relationship (Type. Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

(Daughter) 11552 Janestown Ct. Laurel, MD 20723 Stephanie Durruthy

20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State St\Michael Cemetery 6/13/07 4 □ Donation 5 □ Other (Specify) Oueens, NY

22. Name and Address of Facility SNOWDEN FUNERAL HOME, 21. Signature of Funeral Service Licensee 246 N. Washington St, Rockville, MD 20850

23a. Part1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

End Stage Renal Disease

week Due to (or as a consequence of):

Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4☐Pregnant at time of death

Sepsis

Due to (or as a consequence of):

3 □Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Year

1 ☐ Yes 2 No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

1 🗌 Yes 2 No 3 Probably 4 Munknown

24a. Was an autopsy performed?

1 Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Assisted

Living

25. Was case referred to medical examiner? 1 ☐ Yes 3 No

29b. Signature and title of certifier

Abeda

27. Manner of Death 1 Natural 2 ☐ Accident 5 Pending investigation 6 ☐ Could not be 3 Suicide

Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

29a, Certifier (Check only

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Khan,

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hickory Ridge Lane, Columbia, MD 21044

Registrar

31. Date filed (Month, Day, Year) 11 2007 JUN

Ali

32 egistrar's Signature

10794

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified

			1 - State Amend #3	State of Market FCH	aryland / Del <b>D 06–12–2</b>	partment of 1 007 CNM ertificate of	Death		giene Reg. No. 2	11.7	2019
			1. Decedent's Name (First, Middle	e, Last)				2. Date of De Month	eath Day	Year	3. Time of Death
6	Physici: /Medic		BERNICE J		DEPRO			JUNE	7, 200		9:40P M
1	Examin	er	4a. Facility Name (If not institution			4b. City, Town,	or Location of Deat	h	4c. County	of Death	
		ā	FREDERICK MEM  5. Social Security Number	ORIAL HOSPIT	'AL ge (In yrs. last birthda		DERICK  If Under 24 Hrs	8. Date of Bir	FRED!		
E	Funeral Director		215-16-1176	1 M 2 X F	85 Yrs.	Months Davs		(Month, Da	8, 1921		ace <i>(State or Foreign</i> try) <b>1and</b>
	-		Usual Residence of Decedent					11000	, 1,41		
	show dat	_	10a. State 10b. County		10c. City, Town or	Location				10	od. Inside City Limits  1 ☐ Yes 2X No
	8a-f s	Director	Maryland Frede	rick	Buckey				10 000 000		
	with the	Ë	10e. Street and Number	D41		10f. Zip Code	717		10g. Citizen of W		•
	ns 23	Funeral	3529 Buckeysto	12. Was Decedent	Ever in U.S. 1	3. Was Decedent of If Yes, specify Cul		Specify Yes or No		S.A.	an Indian,
(0	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	μĒ	1 ☐ Never Married 2 ☐ Marri	Armed Forces?	No			to Rican, etc.)		, White, e	etc.
21215-0036	ral", o	l by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	30000	1 ☐ Yes 2 XNo	Specify:		Specify:	Whi	te
2-0	72 h "natu dical	Completed	15. Deceden (Specify only highe	nt's Education est grade completed)	16a. De   ( <i>Gj</i>	cedent's Usual Occu ive kind of work done e. DO NOT use retire	pation during most of wo	rking	16b. Kind of Bu		,
121	within sne. than the Me	ם	Elementary/Secondary (0-12)	College (1-4or	5+1 I	lergy Wif			Chu		louist
d 2	filed withir Hygiene. sther than ent, the Me		17. Father's Name (First, Middle,				T	me (First, Middle	, Maiden Surnam		
lan	id be ental ked o	To Be	Heisse Joh	nson			Ethe	1 Spen	cer		
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene.  If of Health and Mental Hygiene.  If the Zris marked other than "natural" or items 23a or 28a-f show it is marked other than "natural" or items Zris marked outer than "natural" or other traumate event, the Medical Examiner must be notified at		19a. Informant's Name/Relations		19b. Ma	ailing Address (Stree	t and Number or R	ural Route Numb	per, City or Town,	State, Zip	Code) 21717
Ž	1 and 2 Health a em 27 is other trau		Elizabeth Anne	Grove - Dau	ghter 35	29 Buckey	stown Pik	ce, Buck	eystown,	Mary	land
ore	of He of He fiten		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 □ Removal from State	cometent of	position (Name of rematory or other pla		Date	20c. Location -	City or To	wn, State
Ë	Pag ment tant: I		4 □ Dorlation 5 □ Other (S		Druid R	idge Ceme		.2/07	Baltimo		
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once,		21. Signature of Funeral Service	Licensee XIII		22. Name and Addr Moleswort 26401 Rid					20872
	-	П	23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that cause	d the death. Do not	enter the mode of dy	ing, such as cardia	c or respiratory a	irrest,	Tano	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. only one dade on each in	A	t - I	1	14.	C		Onset and Death
1	/Medical		resulting in death)	Due to (or as	a cons quence of):	ILVI	es v ca	,,,,,	)		
7	Examiner		Sequentially list conditions,	b	Valu	ulact	do cal	D.34	ase		YEATS
	ed sit	ine	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):						
	xecut and II-tran	xan	that initiated events resulting in death) Last	c Due to (or as	a consequence of):						
68760,	sician sician buris	edical Examiner		d							
687	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit			0.							
Вох	h cert ending	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		3 □Ectopic pregnan	01/		1	e of delive	•
B	e deat e attr	sicia	in the past 12 months? 1 ☐ Yes        Yes	4☐Pregnant a		5 ☐ Other (specify)			Mor	nth	Day Year
P.0	res that the de signed by the a be detached f	Phy	9 □ Unknown		A A Itlan in Ab-		form in Dard I	OO - Did	tobacco use contr	lhuda ta dh	a course of death?
ŝ,	signed be d	þ	Part II. Other significant conditi	ons contributing to death t	the suning in the	e underlying cause g	iven in Part I.			3∏ Prob	_
Ö	w requir been si should	Completed	N- 1	100//	17/19/	-			315-235		. –
3ec	ne law has b je 2 s	ם	DIA DETE	2019///	15 14	5 4 11		24a. Was auto	psy p		osy findings available npletion of cause of
Vital Records,	sician; Th certificate rector, pag		25. Was case referred to medica	17 Myel	oma		00 Plant (Pa	1□ Yes	20 No 1	□Yes	2□ No
Ξ		o Be	examiner?	Hospital: Hopati	ent 2 D FR/Outnat	tient 3 DOA	thar:	ath (Check only o	<i>one)</i> idence 6 □Othe	r (Cnasifi	al.
	g Physer this eral di	n: To	27. Manner of Death	28a. Date of Inju	ury 28b. Time	e of 28c. Inju			how injury occurre		<u> </u>
Division	or Attending F after death. Director: After in by the funera	Certification:	1 Natural 5 Pendir investi	igation	ay Year) Injur		Yes 2 No				
i <u>S</u>	er de irecto	tific	3 Suicide 6 Could 4 Homicide determ	ningd   Zoe. Flace Ul III	jury - At home, farm, tc. <i>(Specify)</i>	street, factory, office		28f. Location ( City or To	(Street and Number	er or Rura	I Route Number,
	ital o							L			
	To the Hospital or Attend within 24 hours after death.  To the Funeral Director: /	Medical		ng Physician: To the best I Examiner: On the basis of and manner si	of examination and/o						
	o the	Mec	29b. Signature and title of certific		idieu.	29c. Licer	nse number		29d. Date signed	(Month, i	Day, Year)
	⊢ 3 ⊢ ŏ		/ Anas	of fram	1 15	MDD	16428		6/8	107	7
	5		30. Name and address of person	who completed cause of	death (Item 23a) (Tyr	pe, Print)			- 101	1	
			Casper E. Cli			st 9th St	reet. Fre	ederick,	Marylan	d 21	1701
	Sta	ate	31. Date filed (Month, Day, Year,		rar's Signature	الالعمال			4.	-	

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State	of Marylan	•	artment of H		Mental Hyo	giene	200	0000	
			1 State Registrar			Cei	rtificate of I	Death		Reg. No.	200/	2039	ď
	Physicia	an	Decedent's Name (First, Middle, L.	•	ah Ens	olei			2. Date of Dea Month	Day	Year	3. Time of Death	
	/Medic	al				EVI	45 City Tours of	Location of Death	June		2007 ounty of Death	6:21 A <sup>M</sup>	4
	Examin	er	4a. Facility Name (If not institution, gi		Jm <i>ber)</i>				1				
-			The Auxilia: 5. Social Security Number 6.	ry Sex	7. Age (In yrs.	last hirthday)	If Under 1 Year	hesda If Under 24 Hrs.	8. Date of Birtl	MOI	ntgome	ery place (State or Foreign	$\dashv$
	Funeral Director			1 □ M 2 🛣 F	8	Vre	Months Days	Hours Min.	8. Date of Birtl (Month, Day March	, Year)	Cou	ntry)	
be			Usual Residence of Decedent		Q.	9			March	13,1	710	Hawaii	
	yland <b>ov</b> at		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits	
	a-fst	ctor	Maryland Montg	omerv			Bethe	sda				X Yes 2 No	
	th the	Director	10e. Street and Number				10f. Zip Code			10g. Citizer	n of What Cou	ntry?	
	23a ust b		5501 Southwick	Stree	t			20817		II.S.	Δ		
	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	Funeral	11. Marital Status	Armed F		.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14.	Race - Americ Black, White,	can Indian, etc.	
36	s afte , or if amin	by Fi	1 Never Married 2 Married	1 ☐ Yes If Yes, G	2X No		1 □ Yes 🎾 No	Specify:		S	pecify: Whi	ita	
5-0036	hour hural' al Ex		3 Midowed 4 ☐ Divorced	Year or I	Dates.	I 16a Dece	dent's Usual Occup	ation			of Business/In	4	
ည်	within 72 lene. than "na he Mcdic	Completed	15. Decedent's I (Specify only highest g	rade completed		(Give	kind of work done	during most of wor d)	rking	700. Talla	Of Dualification	dustry	
7.	withi iene. thar thar	E C	Elementary/Secondary (0-12)	College	(1-4or 5+)	Dwo	acasina			Farm	1		
0	be filed within 72 hours after death with the Marylar Hydjene.  4 other than "natural", or items 23a or 28a-f show event, the M-dical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Las	st)		PLO	cessing	18. Mother's Nan	ne (First, Middle,				
<u>la</u>	lid be lental rked c	To B		Bunii	ro Tan	aka		Misao	Kasama				
Maryland	2 should and Men Is marke aumatic		19a. Informant's Name/Relationship	_			ng Address (Street				own, State, Zij	c Code)	
	2 # 2 # E	. 1	Frances E. Fra 20a. Method of Disposition	ncis/D	aughte	r 3625	Fulton	St.N.	w Was	hing	ton.D.	C.20007	
e G	es 1 a of Hea filtern rothe					cemeterv, cre	matory or other biad	ie) ,		20c. Loca	tion - City or T	own, State	
Ĕ	Page nent c int: If iny or		Marial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			urel	Lawn Cer	netery/	23/07 <del>[</del>	pper	Deerf	N.J. ield TVP	
Balt more,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Lice	ensee	1	2:	2. Name and Addre					hapel, P.	_
מ	8 2 E 8		michael I ha	assulli		6	009 Har	ford Ro	ad Ba	ltima	ore.Ma	ryland21	1 21
			23a. Part1. Enter the disease, or co- shock, or heart failure. List only	mair ations that y one cause on	caused the deal	th. Do not en	ter the mode of dyir	ng, such as cardia	or respiratory ar	rest,	0.50	Approximate Interval Between	-
1	Physician		Immediate Cause (Final disease or condition		sis							Onset and Death	
	/Medical*		resulting in death)		o (or as a consec	quence of):							
	Examiner		Sequentially list conditions.				illness						
1	Sit 3d	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	o (or as a consec	uence of):							
de	be executed Iclan and burial-transit	Examine	that initiated events resulting in death) Last	cThr	combocy o (or as a consec	tosen	ia						_
8760,	cate be executed physiclan and the burial-transit												
28/	requires that the death certificate een signed by the attending physi hould be detached for use as the I	Physician/Medical		►d. — <del>Lc</del> t	akocyto	sis							-
×	leath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	utcome pf pregn	ancy				230	d. Date of deliv	verv	
X R R	eath atter for u	ciar	in the past 12 months?		birth 2 Feta		☐Ectopic pregnancy ☐ Other (specify) _	/			Month	Day Year	
o.	the of y the control of the control	ıysi	1 □ Yes 2X No 9 □ Unknown	9□Unk									
 J	w requires that the di been signed by the should be detached	by PI	Part II. Other significant conditions	contributing to	death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use	contribute to 1	the cause of death?	
<b>Records</b> ,	quire; n sig nld be	q p	Dementia m	oderat	e to s	evere			101	es 🏋	No 3 ☐ Pro	bably 4 ☐ Unknown	
ပ္ပ		lete							24a. Was		24b. Were aut	opsy findings available	T
	The law I	Completed							autop perfo 1□ Yes	rmed?	prior to co death? 1 ☐ Yes	mpletion of cause of 2 No	
VItal	sician: The law certificate has b irector, page 2 s	Be C	25. Was case referred to medical					26. Place of Dea	ath (Check only o	ne)	-11-11-11-11-11-11-11-11-11-11-11-11-11	27 110	
>	ysici is cei direc	0	examiner? 1 ☐ Yes <b>X</b> ☐ No	Hospital: 1	Inpatient 2	] ER/Outpatie	nt 3 DOA Oth	er: 4 D Nursing H	lome 5 ☐ Resid	lence 61/2	ASSIS Jother (Speci	ted Livin	g
٥	ig Ph ter th neral	Ë	27. Manner of Death		e of Injury onth, Day Year)	28b. Time o	f 28c. Injui Wor	y at k?	28d. Describe h			"Facilit	У
Ö	erdir ah. or Af	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigati	on				Yes 2 □ No					
DIVISION	r Atte	Certification:	3 Suicide 6 Could not 4 Homicide determine	d   20e. Plac	ce of injury - At h ding, etc. (Speci	ome, farm, st	reet, factory, office		28f. Location (5 City or Tox		Number or Rur	al Route Number,	
3	italo ralon edir	Ş			<u>.</u>								
	Hosp 4 hou Fune ely fil	edical	(Check only 2 Medical Ex	aminer: On the	basis of examin		th occurred at the ti evestigation, in my o						
	To the Hospital or Attending Physician: within 24 hours, flet dealh. To the Funeral Director After this certifica completely filled in by the funeral director,	Med	one) 29b. Signature and title of certifier	and ma	nner stated.		29c. Licens	e number		29d Date	signed (Month	Day Yearl	-
1	F ≱ F 8		255. Signature and this of Certifier	~	M								
Ī			m			m 00c) /T		5579		une	17,20	0 /	
	18		30. Name and address of sucon what Susan J. Mil				Hill Te	rraco	Rothor	da M	ח אוני ע	316	
	Sta	te.		32.	Registrar's Sign	ature	W. 2	rrace	periles	ua,M	D. 200	טוט	$\dashv$
	Registi		31. Date filed (Month Pay, Year) JUN 2 5 20	07 Jan	Registrar's Sign	A TON							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra AMEND#12a(b-d), 25, 260erMD6/14/07, BMC Partificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 6:31 a M 7 2007 Eraifej Rania Nazmi June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery General Hospital Montgomery If Under 1 Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 1 □ M 2 🕱 F 28 Director April 5, 1979 Jordan Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 9m 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1√ Yes 2 No Funeral Director U.A.E. N/A Sharjah 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number #506 a or ns 23a (must b King Faisal Street, Al Zubaidai Bldg., Block A Jordan N/A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? "natural", or items Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Specify: White 1 ☐ Yes 2K No Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical alth and Mental Hygiene.

27 Is marked other than "
r traumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nazmi Eraifej Sara Al-Khalil ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health an
Important: If Item 27 Is a
any Injury or other trau
once. Nazmi M. Eraifej/Father 3031 Aquarius Avenue, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 10, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Norbeck Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2007 Olney, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring. MD 20901 Approximate
Interval Between
Onset and Death
Months
10 - Years 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Pulmonary Hypertension /Medical Due to (or, as a consequence of): Autoimmune Hepatitis **Examiner** Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last iner Due to (or as a consequence of) Mixed Connective Tissue Disorder Months be execute Exami physician and is the burial-tran Due to (or as a consequence of) Physician/Medical Ticena the death certificate the attending p as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes XX No 3 Probably 4 Unknown Completed neec 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? /es 2 \sum No page certificate 1X Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA Yes - EDA 2 ☐ ₹R/Outpatient After this of funeral direction ို 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury ospitat o.
4 hours after dea.
--aral Director: After 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Within 24 hours. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number and title of certifie 29b. Signatury 3 06-08-2007 ( 1 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) 1 1 2007 JUN



Maryland 21215-0036

Baltimore,

Box 68760.

P.O.

Division or Vital Records,

ed#30		1 - For State Registrar 6/14/07, M.	State of .S. Kent	Marylan Co.				lealth and <i>Death</i>	Mental Hy	/giene Reg. No.	2007	20	40(
		1. Decedent's Name (First, Middle, L.							2. Date of D Month	eath Day	Year	3. Time o	of Death
Physici /Medic		Anita Diane Ernes	st						June	12	2007	8:51	a M
Examin		4a. Facility Name (If not institution, gr		oer)		4b. City,	Town, c	or Location of Dea	ith	4c.	County of Deat	h	
		201 Baxter Rd.				Sud1	ers	ville		Qt	ueen An	ne's	
Funeral				. Age (In yrs. i	last birthday)	If Under	1 Year Days			irth av. Year)	9. Birt	hplace (State untry)	or Foreigi
Director		474-28-2389	1 ☐ M 2 🗗 F	76	Yrs.	WOTHINS	Days	710015	09-07-			ssouri	
S 22		Usual Residence of Decedent		10a Cib	Taura and							10d. Inside C	City Limite
I', or iteme 23a or 28e-f ehow xaminer must be notified at	_	MD 10b. County Oueen	Annos		y, Town or Lo udlers		_						s 2 ⊋No
9	cto	TID Queen		٥	uulels								- X
0 2 20 0 20 0 20 0 20 0 20 0 20 0 20 0	Fe	10e. Street and Number				10f. Zip	Code			10g. Citi	zen of What Co	untry?	
3	Funeral Director	201 Baxter Road					216				USA		
9	rue	11. Marital Status	12. Was Deced	es?	.S. 13.	Was Dece If Yes, spe	dent of I cify Cub	Hispanic Origin? ( an, Mexican, Pue	Specify Yes or N irto Rican, etc.)		<ol> <li>Race - Ame Black, Whit</li> </ol>	e, etc.	
	by Fi	1 Never Married 2 Married	1 ☐ Yes 2 If Yes, Give Year or Dat	₩No		1 🗆 Yes	2 □X\0	Specify:			Specify: wh	ite	
4	D D	3 ☑ Widowed 4 ☐ Divorced		θS:	16a Daga	deetle blev	al Ossur	nation		16h Kii	nd of Business	Industry	
	Completed	15. Decedent's l (Specify only highest g	rade completed)		(Give	dent's Usu kind of wo DO NOT u	rk done	during most of w	orking	IOD. KII	ng or business	industry	
	E G	Elementary/Secondary (0-12)	College (1-	for 5+)							_		
al T	ပိ	12 17. Father's Name (First, Middle, Las	<u>Z</u>		Se.	creta	ary_	18 Mother's Na	ame (First, Middle	e. Maiden	Insura	nce	
	Be												
	2	Rae Ellsworth			10h Maili		- /Ctrant	N1ta t and Number or F	Ellswoi		Tour State	Zin Code l	
other traumatic event, it s m	1	19a. Informant's Name/Relationship  Janet Bowers-dau				-		oad Sud					
		20a. Method of Disposition	gircer	20h P	Place of Disp			.oau suu	Date	9	cation - City or		
once.		1 GBurial 2 Cremation 3	☐Removal from S	ate	emetery, cre	matory or	other pla			200. 20	oution Oily of	rom, claro	
ì		4 ☐Donation 5 ☐ Other (Spec		Su	dlersy				15-2007		dlersvi		
g		21. Signature of Funeral Service Lic	ensee		2	2. Name a	nd Addre	ess of Facility Fe	llows, H	le1fe	nbein &	Newna	m
ā		Gren Jella	~			30_S <sub>1</sub>	eer	Nuau	hesterto		MD 2162	-	
		23a. Rant 1. Enter the disease, or co shock, or heart failure. List on	mplications that ca y one cause on ea	used the deatl ch line.	h. Do not en	ter the mo	de of dyi	ing, such as cardi	ac or respiratory	arrest,		Approxima Interval Be Onset and	etween
ian		Immediate Cause (Final disease or condition	LU	NG	CAN	CER	W	ITH BRA	IN ME	TAST	<b>TASES</b>	200 6	near
cal		resulting in death)	Due to (o	r as a conseq									-
er		Conventially list conditions	b										
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		r as a cons <del>o</del> q	uence of):								
	Examiner	that initiated events	c										
	m	resulting in death) Last	Due to (o	r as a conseq	uence of):								
	Ilcal		d										
	Physician/Med	IF FEMALE:	Tarana and a										
	an/	23b. Was decedent pregnant in the past 12 months?		th 2 ☐ Feta	I death 3	□Ectopic p		су		1	23d. Date of de Month	ivery Day	Year
	200	1 ☐ Yes 2 No 9 ☐ Unknown	4∐Pregna 9□ Unknov	nt at time of d vn	leath 5	Other (s	pecify) _					,	
	F.			45 5 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4				i= D+4 l	220 Die	tobacco i	use contribute to	the cause of	i death?
	2	Part II. Other significant conditions		-	-					Yes 2	a s		]Unknown
	ted	CHRONIC OBS	TRUCTI	IE PL	LLMO	VAK	1 1	DISCASE		1185 21	TIMO SPET	ODADIY 4	Johnstown
	Completed								24a. Wa	opsy	24b. Were a	utopsy finding completion of	s available cause of
	0								per 1 ☐ Yes	formed? 2 A No	death?	2 No	
	Be C	25. Was case referred to medical examiner?						26. Place of D	eath (Check only	one)			
	<b>To E</b>	examiner/ 1 ☐ Yes 2 😾 No	Hospital: 1   In	patient 2 🗆	ER/Outpatie	nt 3 D	OA Ot	ther: 4 🗌 Nursing	Home 5 ⊠ Re	sidence	6 □Other (Spe	cify)	
	Ë	27. Manner of Death	28a. Date of	Injury , Day Year)	28b. Time of	of	28c. Inju	ury at	28d. Describe	how injur	y occurred		
	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigat		,,,	,,	м		Yes 2□No					
	S	3 Suicide 6 Could not	28e. Place	of Injury - At hig, etc. (Specif		treet, factor	ry, office		28f. Location City or T	(Street an	d Number or R	ural Route Nu	mber,
	Certification:		ballan	g, oto. (opoon	The same						<b>,</b>		
			Physician: To the I										(c)
	Medical	one) 2 Medical Ex	aminer: On the ba		andri and/of I	-vestigatio	ı, ın my	ориноп, авати ос	curred at the time	, uale and	i piace, and du	, to trie cause	(3)
	Σ	29b. Signatur and title of certifier	110			29		nse number		29d. Da	te signed (Mon	h, Day, Year) 1	
		Dun H	the				D	00415	87	6	114	1200	7
		30. Name and address of person wh	o completed cause	of death (Iter	n 23a) (Type	, Print) <sub>1 2</sub>	2 St	peer Rd.	Charter	torm	MD 2	620	
		Helen Noble	610	Date	chine	0	111	C 66	STOL	- m	D al	600	
Sta	ate	31. Date filed (Month, Day, Year)		gi ar's Signa		-							
egist	rar	I JUN I	4 2007	1		A second	0						

# Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed and Records, P.O. Box 68760, certificate Division or Vital

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 200 Thomas Warren Engelke un e /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Talbor aston Memoria If Under 1 Year | If Under 24 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Hours Min Country 1 € M 2 ☐ F Yrs. 2-20-1938 69 Annapolis, MD 219-26-3388 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Oueen Annes Church Hill 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 205 Pinder Hill Road 21623 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1¥1Yes 2 ☐ No If Yes, Give 1060 1 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married white If Yes, Give Year or Dates: 1960-1972 1 ☐ Yes 2 No Specify Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pastor Ministries 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental Int: If Item 27 is marked of Harry J. Engelke Marion Jewell 19a. Informant's Name/Relationship (Type. Print) Evelyn Engelke-wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 Pinder Hill Road Church Hill, MD 21623 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State permit. Page Department o Important: If any Injury or June 13, 2007 Stevensville, MD Chesapeake Center 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility
Fellows, Helfenbein, Newnam Funeral Home PA Kup 130 Speer Road Chestertown, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Colon Carre Morth disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Emer underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-trar Due to (or as a consequence of) Physician/Medical as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for Day in the past 12 months? 4☐Pregnant at time of deeth 5 ☐ Other (specify) 1 ☐ Yes 2 No detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Compression 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2: autopsy performed 1 ☐ Yes 2 ☐ No 0 25. Was case referred to dedical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral or 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 25 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) gton St. Easter, NS 2/60/ 175 Ms 32. Registrar's Signature 31. Date filed (Month, Day State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

07-04608 Richard Gaskins Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

GIGIG GGAINE		1- For State Crivial yiand / Depart	ficate of E		intai riygi		J. No.	1 2000
Physiciar edical Examin	1	1. Decedent's Name (First, Middle,Last) Richard G. Gaskins				Date of Death Month UNE 16, 20	Day Year 007	3. Time of Death 1440 hrs
		4a. Facility Name (if not institution, give street and number) 1912 West Street # 340		City, Town, or Locatio Annapolis	n of Death	<u>.</u>	4c. County of Dea	
Funeral Director		5. Social Security Number 251 98 6027		If Under 1 Year If Un Months Days Hou		Date of Birth 4 / 1 5 / 1	953 Fore	sirthplace (State or eign SC country)
Aaryland 28a-f show any 1 at once		MD Anne Arundel ANNA	own or Location			140	g. Citizen of What Co	10d. Inside City Limits 1 Yes 2 X No
the Mary Sa or 28a stifted at	<u>ē</u>	10e. Street and Number 1911 Westbridge Drive #340		0f. Zip Code 21401			JSA	untry?
	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 X Divorced If Yes, Give Year or Paties:  12. Was Decedent Ever in U.S.  Armed Forces? X No If Yes, Give Year or Paties:	If Yes	Decedent of Hispanic C specify Cuban, Mexic es 2XX No speci	an, Puerto Ric		White, etc.	erican Indian, Black, hite
2 hours		15. Decedent's Education (Specify only highest grade completed) 1  Elementary/Secondary (0-12) College (1-4 or 5+)		Usual Occupation (Given to fixed to the control of		done	16b. Kind of Busines	s/Industry
215-0036 be filed within 72 ntal Hygiene. rked other than ent, th. M. di al	Completed	2 17. Father's Name (First, Middle, Last)	P1umbe		ner's Name (Fi	et Middle M	Plumbing   aiden Surname	
ID 21215-00; should be filed within and Mental Hygiene. 7 is marked other it matic event, the Med	8	Richard Dexter Gaskins		G1	adys He	rndon		
and 2 should lealth and Mer ten 27 is man traumatic ev	2	19a. Informant's Name/Relationship (Type, Print)  R. Dexter Gaskins (father)		ddress (Street and N hree Mile				
		1 Burial 2 X Cremation 3 Removal from State Met 1 4 Donation 5 Other Specify:	ematory or other ropolit	an Cremato	ry 6/2	o/07	20c. Location - City Alexandr	ia VA
Ealti p.mit. Le partir ir ports		21. Signature of Funeral Service Licensee  Mulanu Nullulu	22. Nar	ne and Address of Fac ent Funera	1 & Cre	mation	n Svcs/ <sup>Fal</sup>	ls Church VA apolis MD
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. D failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	und	mode of dying, such a	s cardiac or re	spiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
	۱.	Sequentially list conditions, if any, leading to immediate  b.  Due to (or as a consequence of):			_			
n) l	Examiner	(Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):					<u> </u>	1
executed an and all - transit		d. UNPENDED AMENDED						
760, cate be ex physician the burial		IF FEMALE: 23c. If yes, outcome of pregna	ancy				23d. Date of deliv	
Box 687 e death certific	sicial	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  1 Unknown	h ====================================	death 3 Ector	opic pregnancy		Month	Day Year
res that the d	by Phys	Part II. Other significant conditions contributing to death but not res	ulting in the un	derlying cause given in	Part I.			to the cause of death? robably 4 Unknown
cords aw requi	Completed					24a. Was a autops perfor	sy prior t med? death	
Vital Recysician: The list certificate lidirector, page	8	25. Was case referred to medical examiner?  Hospital:   Inpatient   2   E	R/Outpatient	26.Place of Dea			Residence 6 ✔ Ot	her: Scene
ion of V trending Physeath for: After thi	ation: To	27. Manner of Death  1 Natural 5 Pending FOUND: 1	28b. Time of Inju FOUND: 1446 hrs		/ork? 28		now injury occurred	
Division pital or Attent ours after death teral Director: filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify) Multi-Family		factory, office building		or Town, S		Rural Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 2 Certifying Physician: To the best of my knowledge one) 2 Medical Examiner: On the basis of examination and and manner stated.	e, death occurre					
	Ž	29b. Signature and title of certifier  1004  101  101  101  101  101  101  1		29c. License numb	per		29d. Date signed (/	
5		30. Name and address of person who completed cause of death (Item 2 Margarita Korell MD. Assistant Medical Examine		nn Street, Baltimo	ore, MD 21	201		
Sta Registr		31. Date filed (Month, Day, Year)  JUN 2 5 2007  Registrar's Signature	double	,				
DHMH 17 Rev 1/20			ORIGINAL					OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** June 7, 2007 1:20 A M Rudolf Oskar Geissler /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Doctors Community Hospital Lanham If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**▼** M 2□ F Hours 92 Aug 19, 1914 262-58-7592 Germany Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits ıral", or items 23a or 28a-f show I Examiner must be notified at Maryland Prince George's Hyattsville 1 X Yes 2 □ No Director e filed within 72 hours after death with the I al Hygiene. other than "natural", or items 23a or 28a-10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20781 USA 5112 Crittenden Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 XNo Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) German Embassy Elementary/Secondary (0-12) College (1-4or 5+) Washington, DC Chauffeur 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental F is marked of Be pe Frieda Meta Kunath Ernst Rudolph Geissler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra Hildegard Frida Geissler-Wife 5112 Crittenden St., Hyattsville, MD 20781 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State George Washington Cemetery 6/11/2007 4 ☐ Donation 5 ☐ Other (Specify) Adelphi, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licens 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1 Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ran se on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** FAILURE RESPI TORY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ALZIEHMERS Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine certificate be executed attending physician and for use as the burial-transi ATRIAL FIBRILLATION resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 9□Unknown 5 Other (specify) signed by the a P.0. 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No ospital or Attending Physician: hours after death.

Ineral Director: After this certifical by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 217-NO 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital of within 24 hours aft To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month

29c. License number

1000 500 951

Reverdole

29d. Date signed (Month, Day, Year)

20737

mo

and manner stated.

SAID

32. Registrar's Sign

Kenel work

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**UNK UNK** 

Johns F. Gathers
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death June 2, 2007 Medical Examiner 0344 hrs Jahru F. Gathers 4a. Facility Name (if not institution, give street and number) c. County of Death 4b. City, Town, or Location of Death Prince George's Hospital Cheverly Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** oreign Months Days Hours Director 1 X M 2 F 578-04-1963 01/09/1980 DC Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show e notified at once. 1 X Yes 2 No 28a-f show DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 125 P St., 20024 United States 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. White, etc. Armed Forces? 1 X Never Married 2 Yes þ Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after d
Department of Health and Mental Ptygiene.
Importants If item 27 is marked other than "natural", or
injury or other trannatic event, the Medical Examiner. If Yes, Give Year Widowed 4 Divorced 1 Yes 2 X No specify: Black ۾ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ 12+h Roofing Private 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Charles Kay Yvonne Halloway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirleena Lewis/Sister 750 Barnaby St., SE #202, Wash., DC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) 1 XBurial 2 Cremation 3 Mt. Olivet Cemetery 6/12/2007 Wash., DC Donation 5 Other Specify 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., NE Wash., DC 20019 Approximate Interval . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** List only one cause on each line Between Onset and /Medical a, Complications of Gunshot Wounds Death Immediat Cause (Final disease vaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical UNPENDED ned by the attending physician detached for use as the burial -AMENDED Box 68760. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 3 Ectopic pregnancy Fetal death Month Year 2 Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 ✔ No 3 Probably 4 Unknown Completed Division of Vital Records, has been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of page 2 s performed? death? certificate Yes 2 ✓ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient ER/Outpatient 3 DOA Nursing Home 5 ٩ 1 V Yes 28a. Date of Injury (Month, Day Year) Apr 30, 2007 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work' Certification: Subject shot Natural 2200 hrs 5 Pending Yes 2 V No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f, Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 3900 Clay Place N.E., Washington, DC (Specify) Hospital 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 2, 2007 30. Name and address of person who completed cause of death (Item 23a)

31. Date filed (Month, Day, Yea State Registra

Carol Allan, MD

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** June 10, 2007 03:05M /Medical Robert W. Gerhards 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Atlantic General Hospital Berlin Worcester 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 5-22-1948 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** PA 1**X** M 2□ F Months Days Hours 175-40-5136 59 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show t be notified at 10b. County 1X Yes 2 No Director PA Lebanon Jonestown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with Inent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or it yor other traumatic event, the Medical Examiner must be n 470 Darlington Ave. 17038 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes, 2 □ No If Yes, Give Year or Dates; NaVy 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Steam Plant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Gerhards Lina Chapman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 470 Darlington Ave., Jonestown, Pa. 17038 Kimberly Ambacher 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iten
any injury or ott 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. 6-11-07 Frankford, DE 22. Name and Address of Facility The Burbage Funeral Home 21. Signalup of Funeral Service Vicensee 108 William St., Berlin, Md. 21811 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ASCUD YEARS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Box 68760. physician attending p for use as as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the 9☐Unknown 9 ☐ Unknown by signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has t page 2 s certificate Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□ No this ို funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director: A 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who complete a use of death (Item 23a) (Type, Print) 263 SNOW ST. ZIVO ETTT. 32. Registrar's Signature DIMY 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** JUNE Julia Mae Hogan 15 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Harford Bel Air Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** 1 M 2 F Months 10,1941 Alabama Director April 270-38-0180 66 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1√ Yes 2 No Director Hamilton Ohio Cincinatti 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe o 45208 U. S. Α. "natural", or items 23a 3057 O'Brion Street Apt.#205 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Tyes 2 No
If Yes, Give
Year or Dates: 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: Black **X**□Widowed 4□Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bowling Alley/Recre-Elementary/Secondary (0-12) College (1-4or 5+) 12 Manger 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dorotha Jones ဥ Julia C. Gant 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S 1325 Kelsey Court Bel Air, Maryland 21015 Rommel Cannedy/Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cincinatti, Ohio 06/16/07 Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P. 6009 Harford Road Baltimore, Maryland 21 michael hiarnello Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Hypotherica Cardlue to (or as a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Dav Year 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes asthma Division or Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ★ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) DME BERNARD YKNA MI) 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend titem Maryland / Bepartment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Catherine Margaret Havs Jun 19, 2007 1:05am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Beverly Living Center of Cumberland Cumberland Allegany If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number Date of Birth (Month, Day, Year) Oct 8, 1907 6. Sex 9. Birthplace (State or Foreign **Funeral** MD Days 1 □ M 2 □ F Director 214-07-4242 99 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at MD Allegany Cumberland Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 512 Winifred Road 10f. Zip Code 10g. Citizen of What Country? ms 23a or 2 must be n 701 Furnace St. Apt. 105 21502 items 23a USA by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status f Health and Mental Hygiene. Item 27 is marked other than "natural", or Item other traumatic event, the Medical Examiner I Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ **X**o 3 X Widowed 4 □ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) laborer Celanese Corp 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elmer Miller Lillie Weigand Miller ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Andrews 10105 Shortest Day Rd, LaVale niece MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Zion Reformed Church Cemetery 20c. Location - City or Town, State permit. Pages I Department of H Important: If ite any injury or ot 1 → Burial 2 □ Cremation 3 □ Removal from State 6/21/2007 Cumberland MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun ral Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a Ant Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final reprovas **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) signed by the attending physician and the detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Year Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 22 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
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State Registrar SUNIL

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D.

32 Registrar's Signature

GUPTA

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, 685 KENTAVE., CUMBARUND, MD 91502

			For Stata Registrar	State of M	faryland		artmeni rtificate			Mental Hy	ygien Reg. N	200	7	204	00
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	Funeral			5. Sex 7. A	ge (In yrs. las	st birthday) Yrs.	Months	1 Year Days	If Under 24 Hrs Hours Min.		irth <i>ay, Year</i>	)	<ol> <li>Birthr</li> <li>Cour</li> </ol>	place (State ntry)	or Foreign
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<b>Maryland</b> d 2 should be file	ked c	To Be	John Karydakis						Bess	ie Cour	embi	.s			
Shou	mar mer	-	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	ng Address	(Street a	and Number or Ri	ural Route Numi	ber, City	or Town, S	tate. Zic	Code)	
ğ Z	itha 27 is r treu		Greg Hollingsw	orth - Son		1006	Jams	ie C	ove Dr.,	Charle	ston	. SC	294	41.2	
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altimore, mit. Pages 1 ar	artme orten injur		21. Signature of Funeral Service Li			22	Name and	d Addres	s of Facility			39 Bal			
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1	2)		30. Name and address of person w	no completed cause of	death (Item 2	3a) (Type,	Print)			90 0				12-8	
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DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

1 - For State Registrar

		_	For State Registrar		Cer	tificate of De	ath		Reg. No.	007	20409
	Physicia	an	1. Decedent's Name (First, Middle, Last)	Jave				2. Date of Dea Month June	Day 9	2007	3. Time of Death 9:48 A <sup>M</sup>
	/Medic Examin		Deborah D.  4a. Facility Name (If not institution, give s			4b. City, Town, or Loc	ation of Death	oune		County of Death	9.40 A
			9624 W. 4th St.			Ocean Cit	•			rcester	
1	Funeral Director		221-38-6164	M 2 ☐ F 7. Age (In yr.	s. last birthday) _ Yrs.	Months Days H	ours Min.	8. Date of Birt (Month, Day 10-02-	h /, Ye <i>ar)</i> 1951	Coun	lace (State or Foreign try) aware
	f show	or	Usual Residence of Decedent  10a. State 10b. County  MD Worceste		cean Ci					1	0d. Inside City Limits  ↑  XYes 2 No
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	th with		9624 W. 4th St.			21842			USA		
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yıa	ould b Menta larked	To I	Gene Deery			11		Anders		T Ct-t- 7:-	Code
, Mai	and 2 sh ealth and n 27 is m	i	19a. Informant's Name/Relationship (Ty, Kelly Hays (daught	er)	9624	g Address (Street and 1 W. 4th St	t., Oce	an City	, Md.	21842	
ם ס	Pa In the land		20a. Method of Disposition  1 ☐ Burial 2XXCremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)		ape Hen	sition (Name of natory or other place) lopen Crem.	6-11		Frank	cation - City or To	E
חשב	permit. Departn Importa any inju		21. Signatur 1 Funeral Service License	Edward		Name and Address of D8 William			_		ome
	Physicían /Medical Examíner	20.00	23a. Parf. Enter the disease, or complishook, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	Due to (or as a cons	equence of):					tures,	Approximate Interval Between Onset and Death 7 months
00/00	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons  Due to (or as a cons							
O. DOX o	w requires that the death certifit been signed by the attending I should be detached for use as	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ⊠No 9 □ Unknown	3c. If yes, outcome pf prediction 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)			2	3d. Date of deliv Month	ery Day Year
ב, ב	uires that signed by Id be deta	þ	Part II. Other significant conditions co	ntributing to death but not i	resulting in the u	nderlying cause given in	n Part I.		obacco us		he cause of death?
II Records,	The ate hap page	Completed								24b. Were auto prior to co death? 1 \( \text{Yes}	opsy findings available impletion of cause of
N 11.0	Physician: r this certificaral director,	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ X No	Hospital: 1 ☐ Inpatient 2	TER/Outpation	Othor		th (Check only		G □Other (Speci	5.1
5	g Physer this eral di	n: To	27. Manner of Death	28a. Date of Injury	28b. Time of			28d. Describe			
JIVISION	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	1 XNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - A building, etc. (Spe	t home, farm, str	M 1 ☐ Yes	s 2∐No	28f. Location ( City or To			al Route Number,
_	Hospita 24 hours Funeral stely filled	Medical Co	29a. Certifier 1 X Certifying Phy (Check only one)	sician: To the best of my iner: On the basis of exam and manner stated.	knowledge, deat nination and/or in	h occurred at the time, vestigation, in my opini	date and place ion, death occu	, and due to the rred at the time	cause(s) , date and	and manner as	stated. to the cause(s)
-	To the within To the comple	Me	29b. Signature and title of certifier	Cluz	wo.	29c. License nu				e signed (Month,	
-	T IN		30. Name and address of person who c	ompleted cause of death (	Item 23a) (Type,	Print) Couvil STM	uet, - £	elis bri	y,n	10.2180	0/
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Si		Snorte					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2007 3:40 Beverly Joy Hook June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2X □ F 25, 73 Montana 217-32-4432 Nov. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nature" any injury or other traumatic executions. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Directo Maryland Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 USA 4008 Jeffry Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Specify: White 1 ☐ Yes 2 XNo þ Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Research 4 Mathematician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Dobrovolny Tillie Dorthea Folkerts 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William A. Hook/Husband 4008 Jeffry Street, Wheaton, Maryland 20906 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 20a. Method of Disposition June 8, 1 Burial 2 Cremation 3 ☐Removal from State Metropolitan Crematory 2007 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia Runeral Service Licenses Francis Address Corillins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Myelodysplastic Syndrome with Myeolfibrosis Less than 10 disease or condition resulting in death) /Medical Due to (or as a consequence of): years Examiner Sequentially list conditions, Due to (or as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed burial-tran and resulting in death) Last Due to (or as a consequence of) attending physician Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the at d be detached for 4☐Pregnant at time of death ☐Yes 2☐No 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Atherosclerotic Heart Disease, Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autop performed : 2 \( \text{No} \) spital or Attending Physician: The hours after death.
Ineral Director; After this certificate y filled in by the funeral director, par 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🔼 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760,

State Registrar

Medical

29a, Certifier

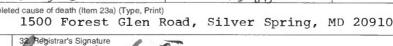
(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ashish Tolia, M.D.

1 1 2007



and manner stated.



1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1100645

29d. Date signed (Month, Day, Year) June 8, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** M. Jerry Hekimian June 1, 2007 12:50 P /Medical 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

Manths Days Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1₽ M 2□ F 578-40-2549 82 Yrs. Nov. Director 28,1924 Syria Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at Maryland Montgomery Chevy Chase Director 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3716 Cardiff Court 20815 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 N Yes 2 No 1945— If Yes, Give Year or Dates: 1947 13. Was Decedent of Hispanic Origin? (Specity Yes or No. If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White <u>م</u> 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Monce. Insurance Broker Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacob Hekimian Jemileh Berejiklian ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3716 Cardiff Ct. Chevy Chase, MD 20815 ce of Disposition (Name of Date 20c. Location - Cit Margot A. Hekimian / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemet | 06/08/2007 | Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Licensee 5130 Wisconsin Ave. NW Washington, DC 20016 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease, shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final Physician INTRACRANIAL HEMORRHAGE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CLOSED HEAD Sequentially list conditions, ma Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed ACCIDENTAL Due to (or as a consequence of) physician sthe burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic predi in the past 12 months? Year Month Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify Ö 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate 2 No or Attending Physician: 86 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P this 27. Manner of Death 28a. Date of Injury 28b Time of 28d. Describe how injury occurred Certification: After (Month, Day Year) 1 Natural 5 Pending investigation TRIP AND 1 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, 3 Tity or Town, State)
3 Tity CARDIFF GURT
CHEXY CHASE, MD 20315 determined 4 ☐ Homicide HOME 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 2D 00 55612 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MORTON JAMES 8600 OLD GEORGETOWN RD BETHERDA, MD

Registrar

State

200

JUND

TEKINIAL

31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 7:30 a<sub>M</sub> June 2007 6 Naomi Hartmann /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Sunrise Assisted Living Silver Spring If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 □ M 2 🕱 F Yrs. Director 088-16-6762 85 February 6, 1922 **Israel** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County a or 28a-f show be notified at fshow 1 ☐ Yes 2 No Director **Burtonsville** Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral", or items 23a Examiner must b 4323 Thistlewood Terrace U.S.A. 20866 death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 X No Specify: Specify. <u>Ş</u> 3 X Widowed 4 ☐ Divorced White Completed 7 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 8 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be . Pages 1 and 2 should be fil Iment of Health and Mental H Iant: If item 27 is marked otl Sarah Levy Solomon Morchy 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4323 Thistlewood Terrace, Burtonsville, Maryland Audrey Scully - Daughter other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 Burial 2 □ Cremation 3 KI Removal from State Beth-El Cemetery 4 Donation 5 Dother (Specify) 6/8/2007 Groton, Connecticut 21. Signature of Funeral Service License 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Arteriosclerotic Cardiovascular Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed and as the burial-tra Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐Ectopic pregnancy Po Day signed by the all d be detached for 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ٥ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 1□ Yes 2 🙀 No 1 ☐ Yes 2 □ No Attending Physician: ector, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 KOther (Specify) Assisted 1 ☐ Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA ို this Living funeral 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Ďay Year) Injury 1 X Natural 5 ☐ Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🛮 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D53367 June 7, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shyamsundar Rajan, M.D., 9801 Georgia Avenue, Silver Spring, Maryland

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN

1 1 2007

Registrar's Signature

DHMH 17 Rev 1/2001

			For State Registrar	State of M	1arylan		artment of H		nd Mental Hy	giene Reg. No.	I amount	20414
			Decedent's Name (First, Middle,)	Last)					2. Date of De Month	the Contract	Vans	3. Time of Death
	Physicia /Medic		Suzanne		Jι	ubuiss	on		June	7, 200	Year 7	12:35 <sup>a м</sup>
	Examin		4a. Facility Name (If not institution, g	give street and number	r)		4b. City, Town, or	r Location of	Death	4c. County	of Death	
	~ ·		3909 Littleton  5. Social Security Number 6		Age (In yrs. I	act hirthday)	Silver If Under 1 Year				tgon	ery place (State or Foreign
	Funeral Director		082-40-4994	1□M 2√2F	82	Yrs.	Months Days	Hours	Min. (Month, Da	iy, Yea <i>r)</i> B <b>. 192</b> 5	Hai	intry)
7	2		Usual Residence of Decedent						Malch	3, 1323	1101	
nel/de	show	_	10a. State 10b. County		10c. City	r, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
d.	28a-f	Director	Maryland Monto	gomery		Silv	er Spring			10g. Citizen of V	What Cou	
thing	a or t			o Ctroot				N.G.		USA		may.
400	ms 23	Funeral	3909 Littleton	12. Was Deceden	nt Ever in U.	S. 13.	2090 Was Decedent of H		in? (Specify Yes or No Puerto Rican, etc.)		e - Amer	ican Indian,
5-0036	J within 72 frous after death with the marylar pipele. I than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at the Medical Examiner must be notified.	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces  1 Yes 2 If Yes, Give Year or Dates	<b>X</b> No		lf Yes, specify Cuba 1 ☐ Yes 2 ☐ No	an, Mexican, Specify:	Puerto Rican, etc.)	Specify	ck, White	, etc. Slack
215-0035	atura		15. Decedent's	Education			dent's Usual Occup		of wording	16b. Kind of Bu	usiness/I	ndustry
	e. an 'n Medi	ed l	(Specify only highest Elementary/Secondary (0-12)	Gollege (1-4o	r 5+)	life.	kind of work done on DO NOT use retired	d) most	or working			
7	Hygiene. other than "sent, he Med	Completed	12			Se	amstress	40.14.45	to bloom of the same		lori	ng
ב ב	ntal Hyg ed othe event,	Be	17. Father's Name (First, Middle, La Lahens Toussa:	•					's Name <i>(First, Middle</i> glantine Jo		ne)	
Maryland d 2 should be file	os I and z should be the the and Mental Item 27 is marked controller transmatic even	ဥ	19a. Informant's Name/Relationship	(Type Print)		19h Maili	on Address (Street		r or Rural Route Numb		State 7	in Code)
Z a	ithan 17 Isi 17 Isi		Margaret Vincen			1	•		eet, Silve:			
စ် နို	of Health of Item 27 Is		20a. Method of Disposition		20b. P		sition (Name of matory or other place		Date	20c. Location -		
OE S	nent of int: If Ik	Ш	1  Burial 2  Cremation 3  Cher (Specific Specific			Heaven Ce		June 16 9 2007		Cons	ng,Maryland	
Baltimore,	Definit. Fages Department of I Important: If Ite any injury or of		21. Signature of Funeral Service Li			F 2	2. Name and Addre	ss of Facility	ins Funeral	] Home I	nc.	ng, marytano
מ מ	S E E S	V. V	Cinche	J Col	e	5	00 Univer	sity ]	Blvd, W.,	Silver S		g. MD 20901
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that cause nly one cause on each	ed the death line.	n. Do not en	er the mode of dyir	ng, such as o	cardiac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	hysician	ř	Immediate Cause (Final disease or condition	_a. Cerebro	ovascu	ılar A	ccident					1 Week
	/Medical Examiner		resulting in death)		as a consequ		Ta d 3					F W
2		<u>.</u>	Sequentially list conditions,	b. Congest	cive E		rallure				-	5 Years
To to	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				, Type II					10 Years
60, be evenifed	n and ial-tra	Exal	that initiated events resulting in death) Last	V	as a consequ		, Type II	<u></u>				10 10415
760,	ate be executed hysician and the burial-transit	ical		d								
29	ng ph	Med	IF FEMALE:					···-				
Box 687	attending p	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1☐Live birth	2 ☐ Feta	Ideath 3[	Ectopic pregnancy	у		l l	te of deli onth	very Day Year
5	by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown		eath 5L	Other (specify) _					
ةِ ـ ב	ed by detac		Part II. Other significant condition	s contributing to death	but not resu	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco use cont	tribute to	the cause of death?
Sp	w requires mans been signed to should be detailed.	d by							1 🗀	Yes 2∰No	3 ☐ Pr	obably 4 Unknown
Hecords,	s beer	Completed							24a. Was	an 24b.	Were au	topsy findings available ompletion of cause of
e g	te has	mo							auto perf 1□ Yes	ormed?	prior to death?  1 🗆 Yes	completion of cause of 2 ☐ No
		Be C	25. Was case referred to medical				- 2	26. Place	of Death (Check only			
_ <	ظ <u>این</u> کے	To E	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpa	atient 2 🗆	ER/Outpatie	nt 3□ DOA Oth	ner: 4 □ Nur	rsing Home 5 A Res	idence 6 □Oth	ner (Spec	cify)
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SIO	r Attendations are death.	cati	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	the		ome form of	M 1 □	Yes 2 N		(Chront and Mount	ha	and Davida Musellan
Division	or An after o Direc in by	Certification:	4 ☐ Homicide determin		etc. (Specify		reet, lactory, office		City or To	wn, State)	Jer or nu	ral Route Number,
	no me nospital or within 24 hours after To the Funeral Director completely filled in b	Medical Co		Physician: To the best xaminer: On the basis and manner	of examina							
4	vithin 2 To the complet	Mec	29b. Signature and title of certifier	and mariner	stated.		29c. Licens	se number		29d. Date signe	d (Monti	n, Day, Year)
)	- 3 + ŏ		> Bewelt	Mouin	-60		D	47682		Jun	e 7,	2007
	1		30. Name and address of person w	ho completed cause of	f death (Item			na Ros	ad, Olney,	MD 2083	2	
	Sta	ite	31. Date filed (Month, Day, Year)		etrar's Signa	turo		9 1.00			_	
	Regist		JUN 11	2007	ne de	Mr. As	anti)					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMAN TITM/20d per PLYS Copies 6/25/17 WS
State of Maryland / Department of Health and Mental Hygiene

amend item 23e per doc, 17, 19a per fb 8669 7-9-07 vt

Reg. No. 2 1 1 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 17, **Physician** 2007 1:35 a.Mm John Michael Kuykendall, Sr. /Medical 4c. County of Death 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Beverly Living Center Cumberland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 6/29/17 9. Birthplace (State or Foreign 5. Social Security Number 7, Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours Min 1**X** M 2 □ Yrs. Director 236-58-1099 89 Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits Show iral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Director WV Mineral Keyser - Reeses Mill 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Rt. 2, Box 232 26726 U.S.A. death \ Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner 1 Never Married 2 Married 1 □ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 'Specify: Specify: Year or Dates: white 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Dairy Farmer Dairy Farm Robert Elijah Kuykendall 18. Mother's Name (First, Middle, Maiden Surname) Lydia Fleek 2 19a, Klizabethelati Anney Kuykendall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 2, Box 232, Keyser, Catherine Kuykendall/wife WV 26726 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/19/07 Johnson/Greenwell 4 ☐ Donation 5 ☐ Other (Specify) Reeses Mill, WV 22. Name and Address of Facility
Markwood Funeral Home, 21. Signature of Funeral Service Licenses Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line. Keyser, WV Approximate Interval Between Onset and Death Immediate Cause (Final the **Physician** disease or condition rarac resulting in death) /Medical Due (or as a consequence of): Examiner 250 Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): Examiner i necords, P.O. Box 68760, E.
The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the bunal-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 2 No 9☐Unknown 9 ☐ Unknown Part If Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Stra X No 3 Probably 4 □Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performe certificate 2 **1** No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Daysing Home 5 Residence 6 Other (Specify) 1 ☐ Yes To the Hospita. ...
within 24 hours after death.
To the Funeral Director: After this c 20 No 2 ER/Outpatient 3 DOA 2 1 Inpatient 27. Manne of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0054411 June 18, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ہا Cumberland, MD 21502 500 Memorial Ave., Callkins, Beverly Μ. 31. Date filed (Marif Nat) Year) 2007 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Registrar

1.

			For State Registrar	State of Ma		artment of F		d Mental Hy	giene Reg. No. 20	0.7	20417
			Decedent's Name (First, Middle, Las	t)				2. Date of Dea	ath		3. Time of Death
	Physicia /Medic		WILLIAM HOWAR	D LEE -SI	<del>}</del>			JUNE_	Day <b>8</b> ,	Year 2007	3:10 P <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, o		Death	4c. County		
Ġ.			FREDERICK MEM  5. Social Security Number 6. So		SPITAL e (In yrs. last birthday	FREDERI  If Under 1 Year		Hrs. 8 Date of Birt		DERICK 9 Birtholas	e (State or Foreign
	Funeral Director			OXM 2□F	83 Yrs.	Months Days		Hrs. 8. Date of Birt (Month, Date June 9,	1923	Country Mary L	)
Sec.			Usual Residence of Decedent								Little On Italia
	anylar show	7	10a. State 10b. County  MD Frede	rick	10c. City, Town or L Carrol					100	. Inside City Limits 1 ☐ Yes 2√2 No
	ith the Marylar or 28a-f show se notified at	Director	10e. Street and Number			10f. Zip Code			10g, Citizen of \	What Country	
	3a or	<u></u>	13860 Old Annapolis	Road		1	21771		United S	states	
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S. 13.	Was Decedent of H	lispanic Origin an, Mexican, F	? (Specify Yes or No- Puerto Rican, etc.)	- 14. Rac	ce - American	
2	s after	by Fu	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 DXYes 2 □ N If Yes, Give		1 ☐ Yes 2 █ <b>X</b> No	Specify:		Specify		
Ś	hour tural	ed b	15. Decedent's Ed	Year or Dates:	16a, Dec	edent's Usual Occup	oation		16b. Kind of B		
2	hin 72 e. an "ne Medic	Completed	(Specify only highest gra	de completed) College (1-4or 5	+)	e kind of work done DO NOT use retire	during most of d)	f working	Baltimor	-	,
1	ed with	S	6th		<u> </u>	stodian				ic Scho	ols 
2	be filk ntal Hi od oth even	Be	17. Father's Name (First, Middle, Last)  Rev. William	H Im Sm			l	Name (First, Middle, rtle Hall	Maiden Surnan	ne)	
3	2 should be and Mental is marked c aumatic eve	은	19a. Informant's Name/Relationship (7			ina Address (Street		or Rural Route Number	er. Citv or Town.	State. Zio C	ode)
2	nd 2 salth ar 27 is rtrau			ife		860 Old Anna			$\gamma$ , MD 217		,
ָרָ בּ	Pages 1 and nent of Health nt: If item 27 iry or other tr	1-3	20a. Method of Disposition 1 X Buriat 2 ☐ Cremation 3 ☐	Damoual from State	20b. Place of Disp cemetery, cri	ematory or other pla	ce)	Date	20c. Location	-	
	ment ment tant: If		4 □ Donation 5 □ Other (Specify	)		UM Ch Cemet		e 12, 2007	Taylorsv	zille, M	D ————————————————————————————————————
a Ca	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 23 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signatur of Funeral Service Ligen	Alle	E	22. Name and Address 212 W. Old	n Funera	1 Home & Ore Road Winfi	matory PA eld. MD	A 21784	
	Value		Za. Part. Enter the disease, or company shock, or heart failure. List only	plications that curied one cause on sich lin						A	pproximate terval Between
ı	Physician		Immediate Cause (Final disease or condition reediting in death)	a	SEPSI	5				3	onset and Death
	/Medical Examiner		death)	,	a consequence of):		1	•			-
pr 356	at offi	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		DECU-B1* a consequence of):	ias ac	CZRV				
	cuted nd ransit	Examiner	that initiated events	C							
Š	cate be executed bhysician and the burial-transit	EX	resulting in death) Last	Due to (or as	a consequence of):						
	icate t physic	dical		d							
3	sician: The law requires that the death certific certificate has been signed by the attending prector, page 2 should be detached for use as!	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Da	ate of delivery	
	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at		☐Ectopic pregnand ☐ Other (specify) _	У		Mo	onth D	ay Year
	nat the d by th etach	Phys	9 ☐ Unknown  Part II. Other significant conditions of		ut not resulting in the	underlying cause di	ven in Part I	23e Did t	obacco use con	tribute to the	cause of death?
, כ	uires tl signe d be d	d by	HYPERTENSION					/4		3 ☐ Probab	
5	w requ	letec	WITH LEFT HE						an 24b.	Were autops	y findings available
ב	The lar te has age 2	Completed by	GERD	and the state of	is, Ajo	CONZP 4	, ce g , c		psy ormed?_	prior to comp death?	letion of cause of
g	ian: irtifica stor, p	Be C	25. Was case referred to medical examiner?				26. Place of	Death (Check only of		1 103 2	2110
5	hysic this ce al dire	To	1 ☐ Yes 2 ☑ No		nt 2 ER/Outpation	SIK 3 LOOM		ing Home 5 ☐ Resid			
	ling P I. After ( funera	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 1 ☐ Accident investigation	28a. Date of Inju (Month, Dat		Wo	ryat rk? ]Yes 2 ∐ No		how injury occur	rred	
	Atten death sctor:	ficat	3 Suicide 6 Could not be	28e. Place of inju	ury - At home, farm, s			28f. Location (3	Street and Numl	ber or Rural F	Route Number,
5	tal or s after al Dire	Certification:	4 ☐ Homicide determined	building, etc	c. (Specify)			City or Tou	wn, State)		
	To the Hospital or Attending Physician: The l within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical		ysician: To the best of niner: On the basis of and manner sta	f examination and/or						
	To the within To the complete	Me	29b. Signature and title of certifier			29c. Licen			29d. Date signe		ay, Year)
	nd		Donelso	n, MD		12	936		6/11	107	
1	IVA		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type	e, Print)	( ac	FREN	68111		21702
ه م	ું Sta	ate	31. Date filed (Month, Day, Year)	32 Registr	ar's Signature	l v	-/	FRED	- ~ > C/C		/ -
	Regist	rar	JUN 1 1 2	307 Septem	w so say	0242					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Lawrence Joseph Link, Sr. 2007 10:50 P.M 6 6 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Dove House Westminster Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 6/9/1916 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours Min 1**X** M 2 □ F 213-07-1040 90 Maryland Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Carroll Keymar 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7010 Keysville Road 21757 United States Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No White Specify. Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Foreman Steel Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacob J. Link Julia Altvater ం 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence Joseph Link, Jr. -son 18415 Upper Beckleysville Road Hampstead, MD 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Hampstead Cemetery 6/11/2007 Hampstead Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eline Funeral Home, 934 South M01490 Main Street Hampstead, MD 21074 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final elastalu disease or condition resulting in death) Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last n Examiner Due to (or as a consequence Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an

**Physician** /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner more.

the burial-transit the attending physician and as esn cate has been signed by the atterpage 2 should be detached for funeral director, this After filled in by the Director: within 24 hours at To the Funeral D

Be

Certification: To

Division or Vital Records, P.O. Box 68760.

autopsy 2 No 1□ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 2 No 1 Yes 27. Manner of Death 1 Natural 2 Accident

3 Suicide

4 Homicide

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be determined

Hospital:

1 Inpatient

28b. Time of Injury

3 DOA

el.

2 ER/Outpatient

28c. Injury at Work? 1 ☐ Yes 2 □ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 64 Other (Specify, 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier

30. Name and adress of person who completed cause of death (Item 23a) (Type, Print)

Westmanster

29d. Date signed (Month, Day, Year)

State Registrar

teo le mid 688 John w. 31. Date filed (Month, Day, Year) JUN 1 1 2007

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. CUU 2. Date of Death nt's Name (First, Middle, Last **Physician** 2007 un /Medical City Town, or Location of Death 4c. County of Death Fagility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, Yea. 1/20/1914 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday **Funeral** Months Days 1 € M 2 □ F 93 Vrs 218-16-6178 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1XXYes 2 No Funeral Director MD Kent Chestertown 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 21620 USA 109 Pine Street 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2€ If Yes, Give Year or Dates: 2(XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify. Specify: Completed by 3€Widowed 4 □ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Painting/Building 10 -0-Painting Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Chance Bradford Lucas ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret LeGrand/ daughter 20958-103 Timber Ridge Terrace, Ashburn, VA 20147 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Chesapeake Cremation 6-11-2007 4 ☐ Donation 5 ☐ Other (Specify) Stevensville, Md 22 Name and Address of Eacility Fellows, Helfenbein & Newnam Funeral Home, P.A. 21. Signature of Fyneral Service Licensee 130 Speer Road, Chestertown, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** /Medical **Examiner** WITH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed KENAL burial-trar Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 2 No Division or Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation n 24 hours after death.

The Funeral Director: Af olderely filled in by the fun 1 ☐ Yes 2 No 2 Accident 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

2 2 0

the

State Registrar

31. Date filed (Month, Day,

e

29b. Signature and title of certifier

29a. Certifier

(Check only one)

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VR. M.D

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

223 High ST. CHester four Wed

29d. Date signed (Month, Day, Year)

07-04570 Guy Allen Lucas

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 20420

Guy Alleri Lucas		For State	Olate	or war your		ificate of	Death			g. No.		
Physician	_	egistrar . Decedent's Name	e (First, Middle,Las	t)					2. Date of Death Month	Day Year		me of Death 942 hrs
N.   Examine	r		Allen Luc						June 15, 2	007 4c. County o		9421115
	4	· ·		e street and number)		4t	D. City, Town, or Bowie	Location of Dea	ith	Prince G		ļ
	L	Bowie Healt			. () [	at histhday)	If Under 1 Year	r If Under 24H	irs 18 Date of Birt	h (MM/DD/YYYY)		ce (State or
Funeral		. Social Security N			e (In yrs. la:		Months Days		lin	0, 1957	Foreign ASP (Resp.)	
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any	_	Jsual Residence o 0a. State	10b. County		10c. City,	Town or Location	n					. Inside City Limits
		MD	Prince G	eorge ! s	ļ	Bowie	<b>-</b>				1 2	X Yes 2 No
Maryland or 28a-f sh	팅	0e. Street and Nu		corge b	<u> </u>		10f. Zip Code		10	g. Citizen of Wh	nat Country?	
or 28	Director	12320 F	Flamingo	Tane			2071	5		USA	A	
		11. Marital Status		12. Was Deceden		S. 13. Was	Decedent of His	spanic Origin? (	Specify Yes or No	- 14. Race White	- American I e, etc.	Indian, Black,
Jeath r iten	Funeral	1 Never Marri	ied 2 X Married	1 Yes 2	X No				10 1100.1			
after of all', of iner of	ᆰ	3 Widowed		or Dates:	<del></del>		Yes 2X No		of work done	Specify:	White	
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36 in 72 han "	be	Elementary/Sec	oridary (0-12)	2	0.7	Elec	trician	*		Delta	Elect	ric Co.
d with	Completed	17. Father's Name	e (First, Middle, Las					18.Mother's Na	me (First, Middle,	Maiden Surname	;)	
21215-0036 Juld be filed within 7 Mental Hygiene marked other than te event, the Medica	Be	Charle	s E. Luca	ıs				Virg	inia R. H	arr		
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Page Page ment of tant:		4 Donation	5 Other Specif	y:	La.				5/20/2007 Beall Fun			ie, rib.
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	İ		funeral Service Lice						y. Bowi		2071	5
fysician	$\dashv$	23a, Part I, Enter	<ul> <li>Zizos per the disease, or com</li> </ul>	plications that cause	d the death	. Do not enter t	ne mode of dying	g, such as cardi	ac or respiratory ar	rest, shock, or he	eart A	approximate Interval Between Onset and
/Medical		failure. List o	only one cause on e	each line. a. <u>Cardiac a</u>								Death
Examiner		Immediate Cause or condition resul	ting in death)	Due to (or as a cor	sequence o	of):						
		Sequentially list of	conditions,	D								
٥.	ine	if any, leading to cause. Enter Und	derlying Cause	Due to (or as a cor	isequence c	or):						
	Examiner	(Disease or injury events resulting i	y that initiated	Due to (or as a cor	sequence o	of):						
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760, cate be execut physician and he burial - tra	Medical	X UNPENDE	:D	A #ENDERH	I,G869,	7/2/07 I	T// 23a,7	27.perME,	g869, 7/19/	07 TT 23d. Date of	of delivery	
3760, ficate by g physic s the bur			nt pregnant in the	23c. If yes, outo	come of preg		etal death 3	Ectopic pr	egnancy	Month	_	Year
lox 687  lox 687  leath certific e attending p for use as th	sician/	past 12 mont			at time of d		ther (Specify)					
Box te death c the atten	Phys		No 9 Unkno	9 Unknown s contributing to de		reculting in the	underlying cause	e given in Part I	23e, Did	tobacco use con	ntribute to the	cause of death?
P.O. Bo. that the de detached f	by P	Part II. Other sig	nificant condition	s contributing to de	ath but not	resulting in the	dideliying oddo	o great in the city				ly 4 Unknown
tal Records, P.C. rian: The law requires that certificate has been signed ector, page 2 should be det		<u> </u>										sy findings available
Ord ord aw rec	Completed					<del></del>			per	opsy formed?	death?	npletion of cause of
Zec The li	Som						00 DI	ace of Death (Cl		2 No	1 Yes	2 No
Z]  // ital   sician: is certifi lirector,	Be (	25. Was case ref examiner?	ferred to medical	Hospital:	-1:1 2 2	✓ ER/Outpatier		To::	lursing Home 5	Residence 6	Other:	
ing Physician: The law requir	ပ	1 ✓ Yes 27. Manner of De	2 No	28a, Date of		28b. Time of		njury at Work?		e how injury occu		
n of ding Ph	ion:	1 X Natural	5 Pending	(Month, Da	ay,Year)		1	Yes 2 N	0			
Division tall or Attendians after death.	icat	2 Accident		28e Place o	f Injury - At	home, farm, str	eet, factory, offic	e building, etc.	28f. Location or Town		nber or Rural	Route Number, City
Divi pital or ours afte eral Dir filled in	Certification:	3 Suicide 4 Homicid	determi						Or TOWN			
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending to completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.		29a Certifier		sician: To the best o	f my knowle	edge, death occ	urred at the time	, date and place	e, and due to the ca	use(s) and man	ner as stated	rause(s)
To the Hosy within 24 hc To the Fun.	Medical			ner:On the basis of e and manner stat	examination ed.	and/or investig			rred at the time, da		igned (Month	
	Ž	29b. Signature a	and title of certifier	( A)			l l	ense number C.M.E.		June 16,		., 20,, . 00,
0:			inte Ir	revoluel	1_			U.IVI.L.		10,		
B			dress of person was Korell MD.	ho completed cause Assistant Medic	of death (Ite cal Exam	em 23a) iner 111	Penn Street,	Baltimore,	MD 21201			
			Anten antiear)		strar's Sign							

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 10:30 ALLISON MILLER MAY 30 2007 Ε. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNE ARUNDEL 2640 EVERGREEN ROAD **ODENTON** If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 F Yrs. **Director** 215-82-8150 **MAY 16** 1971 MARYLAND 36 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits Show ural", or items 23a or 28a-f shor Examiner must be notified at Director 1 XYes 2 No ANNE ARUNDEL ODENTON MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2640 EVERGREEN ROAD 21113 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No BLACK Specify: þ 3 Widowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical once. 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT ADMINISTRATIVE ASSISTANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIE M. COLEMAN BRYANT FERGUSON ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALBERT A. MILLER JR./HUSBAND 2640 EVERGREEN ROAD ODENTON, MARYLAND 21113 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State RESURRECTION CEMETERY 6/4/2007 CLINTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service censee J. B. JENKINS FUNERAL HOME LANDOVER, MARYLAND Approximate Interval Between Onset and Death Enter the disease, o complications that caused the death. Do not enter the mode of dying, only one cause on each line. such as cardiac or respiratory arrest 23a. Part1 Cause (Final or condition g in death) Physician /Medical Due to (or as consequence of); **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Division or Vital Records, P.O. Box 68760, Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ■ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown s been signed by the should be detached anditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1☐ Yes 2 A No 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Yes 22 No Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred eral Director: After filled in by the funer (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 ☐ Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 餐 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 32. Registrar's Sig State Registrar

State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 200<sup>Year</sup> 7 17:00 Abdul Sattar Memon /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Fort Washington Hospital Fort Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 DKM 2 □ F 67 227-06-4385 Yrs. Director 8/8/1939 Pakistan Usual Residence of Decedent with the Maryland 10d, Inside City Limits 10a, State 10b. County 10c. City, Town or Location or 28a-f show in then "neturel", or iteme 23e or 28a-f eho Md. Prince Georges Fort Washington 1 ☐ Yes 2X No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20744 9305 Doris Drive U.S.A. filed within 72 hours after death 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Asian Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade comp (Give kind of work done during most of working life. DO NOT use retired) grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) unemployed none of Heelth and Mental Hygie fitem 27 is marked other r other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peges 1 and 2 should be fill ment of Heelth and Mental H lant: If Item 27 is marked other Ibrahim Mohammad unavailable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gudu Memon / son 9305 Doris Drive, Ft. Washington, Md. 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location · City or Town, State ö 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Depertment of Important: If eny injury or once. George Washington 6/8/2007 Adelphi, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Universal Mortuary 21. Signature of Funeral Service Licensee 411 Kennedy St., NW Washington, DC 20011 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) sete has been signed by the a page 2 should be detached it 1 ☐ Yes 201No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? elu 1 Yes 2 X No director. 25. Was case re rred o medical examiner? Medical Certification; To Be 26. Place of Death (Check only one, 1 Yes 2 Ho Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral is 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending м 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 460 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fort Washington MD 20144 Alikhani IM,D, 11711 Livingston 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 200<sup>Ygar</sup> 3:00A. **Physician** June McCutchen, Sr. Stephen Hardy /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Burtonsville Montgamery Holy Cross Rehab and Nursing Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) June 12, 1921 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min Georgia 1 XM 2 □ F 85 254-24-4815 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 le marked other than "naturel", or thems 23a or 28a-f show any injury or other treumatic event. It is Medical Examination notified alonge. 1 Tes 2 No Silver Spring Maryland Montgomery Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20902 United States 1135 University Blvd., West 12. Was Decedent Ever in U.S. Agpad Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ₹ No Baltimore, Maryland 21215-0036 Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Banking Manager 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Katherine Hardy Pleasant Theodore McCutchen 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14649 Almanac Drive Burtonsville, Maryland 20866 Ann D. Pupjak -daughter 20a. Method of Disposition
1 □ Burial 2 🗴 Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Metropolitan Crematory 6/8/2007 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Sunatur Fun al Service Sicensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CHRONIC OBSTRUCTIVE PULMONAUR DISONSE STACTE FND **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine burial-transit The law requires that the death certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760 attending physician cai as the Physician/Medi IF FEMALE use 23c. If yes, outcome of pregnancy
1□Liva birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Po in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown signed by Part if. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown EMENTA Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 No Division of Vital Hospitel or Attending Physician: 26. Place of Death Check onl one Be 25. Was case referred to medical examiner? Other: 42 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA ٩ 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 28d. Describe how injury occurred 27. Manner of Death Certification: 12 Natural 5 Pending 1 Yes 2 🗌 No death. investigation 2 Accident Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 THomicide To the Hospitel within 24 hours a To the Funerel E 29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signaty and title of certifier Mari 7 28595 asueu 30. Name and address of person who completed cause of death (Item\_23a) (Type, Print), SMITT+

Registrar DHMH 17 Rev 1/2001

State

2835

3 Registrar's Signature

AKIHAMI

JASNEEM (

31. Date filed (Month, Day, Year)

JUN 1 1 2007

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death -Month Year **Physician** regions sune 2007 /Medical Facility Name (If not institution, City, Town, or Location of Death 4c. County of Death Examiner iver Date of Birth (Month, Day, Birthplace (State or Foreign Country) A Security Number s. last birthday 47 Yrs. **Funeral** Hours 1959 Months 1 M 2 F 193-52-2651 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10d. Inside City Limits 1XYes 2 No MD KENT CHESTERTOWN Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21620 USA 101 ADELA WAY Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Tes 2 K If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: BLACK Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) SUPERVISOR Cardianal Health 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LOUISE YOUNG BEN MILLER ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LILLIE MILLER-WIFE 101 Adela Way Chestertown, Md 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Fernwood Cemetery 6/14/07 Phila. PA 4 ☐ Other (Specify) 22. Name and Address of Facility Kenneth Walley Funeral 21. Signature of Funeral Service Licen W00026) Service 821 W St Annapolis, MD 21401 23a. Part. Enter the disease, or complications that cause the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-trar and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) 1 □ Yes 2 □ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown 1 Tyes 2□ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy perform this certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certification: To 4 hours after death. Funeral Director: After this lely filled in by the funeral di 28b. Time of 27. Manrier of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Natural 2 Accident 5 Pending investigation 1 TYes 2 No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral D ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month, Day,

ID

Ms

120

ar's Signature

Road Chartetown, MD 2/620

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			for State Registrar	State of Maryla	-		of Health			2001	20425
			Hegistrar     Decedent's Name (First, Middle, Last	t)			J. Doar		2. Date of Deat		3. Time of Death
	Physici		Carol Ann Mercer						Month 6	,	007 5:05 pm
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, To	own, or Locatio	on of Death		4c. County of I	
П			Chester River Ho	spital		Chas	tertor			Vont	
	Funeral		Social Security Number 6. S	7. Age (In y	rs. last birthday)	tf Under 1 Months	tertown Year If Und Days Hours	ler 24 Hrs. s Min.	8. Date of Birth (Month Day, Feb. 11,	Kent 9.	Birthplace (State or Foreign Country)
	Director		208-40-3/19	□M 2⊠F 57	Yrs.	Willia	Days		Feb.11,	1950 <sub>P</sub>	ennsylvania
	pud *		Usual Residence of Decedent  10a. State 10b. County	10c	City, Town or Lo	ocation					10d. Inside City Limits
	anyla •ho	ក	MD Kent		Rock Ha						1 ☐ Yes 2 ☐ No
	the A	ect	10e. Street and Number		MOCK IIa.	10f. Zip C	Code		1	0g. Citizen of Wha	
	with be or	ā	21086 Haven Roa	đ					,		it Country:
	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or Items 23a or 28s-f ehow int, the Mazical Examiner must be notilised at	Funeral Director	11. Marital Status	12. Was Decedent Ever in	1 U.S. 13.		1661	Origin? (Sp	ecify Yes or No-	USA 14. Race -	American Indian,
(0	riter	표	1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No		_			ecify Yes or No- Rican, etc.)	Black, \	White, etc.
ဇ္ဇ	ours a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give A Year or Dates:		1 □ Yes 2	No Speci	ity:		Specify:	white
21215-0036	72 hc	Completed by	15. Decedent's Ed (Specify only highest gra			dent's Usual	Occupation done during m	nost of work	ina	16b. Kind of Busin	ness/Industry
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7	ygier ygrer her th		12	2	Adı	nin. As	ssistan			Masonry	Supply
and and	be fi	Be	17. Father's Name (First, Middle, Last)							Maiden Sumame)	
Maryland	ould Mer narke	၉	David Brennan						assel Wi		
ā	12 st h and 7 is n traun		19a. Informant's Name/Relationship (7 Edward Mercer/hu	• • • • • • • • • • • • • • • • • • • •		-				, City or Town, Sta MD 21661	
e,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel; or items 23a or 28a-1 ehow appringury or other traumatic event, the Madical Examinat must be notified at another.		20a. Method of Disposition		. Place of Dispo	sition (Name	e of	_		20c. Location - Cit	
Baltimore,	nt of nt of t: if it		1 Burial 2 ☐ Cremation 3 ☐	Removal from State Wa	cemetery, cre shingto	matory or oth	er pjace)	1		Valley F	
臣	artme ortani injury		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of <u>Funeral Service Licen</u>	C.	apel Ce	metery	Address of Far				
Ba	permi Depa impo any ir		1 1.11	_							al Home, P.A.
			23a. Part. Enter the disease, or comp	olications that caused the d						n, MD 216	Approximate
П	Dhusisian		spock, or heart failure. List only immediate Cause (Final								Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. HEMORK  Due to (or as a cons		201	(GANT	_ /	NJ-APPEC	- 6	
	Examiner										
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	nd nd transi	Examiner	Cause (Disease or injury that initiated events	c.							
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٥ ×	uires thet the death certific signed by the attending f d be detached for use as	Physician/Med	IF FEMALE.	22a H vas automa of pro							
Вох	attend attend for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre 1☐Live birth 2☐F	etat death 3	Ectopic preg				23d. Date o Month	f delivery Day Year
о <u>.</u>	the de	ysic	1 □ Yes 2 □ No 9 ■ Unknown	4□Pregnant at time o 9□Unknown	ndeath 5L	Other (spec	спу)				-
	thet t ed by detac		Part II. Other significant conditions of	ontributing to death but not	resulting in the u	nderlying cau	use given in Pa	rt I.	23e. Did tob	acco use contribu	ite to the cause of death?
Records,	uires n sign Id be	d by	CARDIONUGALY				cholla		1 □ Ye	s 2 No 3	Probably 4 Anknown
Ö	w require been si should I	lete	ARTERY 1						24a. Was a	n 24h Wei	re autopsy findings available
Be	he lav e has	Completed	171101-1	130100					autops	ned? prio	r to completion of cause of
	ificat or, pa	ပိ	25. Was case referred to medical				ac Die	and of Doot	1 Yes 2 h (Check only on		Yes 2□ No
>	Physician: The la r this certificate hai ral director, page 2	0 0	avaminar?	Hospital: 1 ☐ Inpatient 2	R/Outpatie	nt 3 DOA	Other			ence 6 Other (	(Spacehr)
ō	9 Phy er thi	H	27. Manner of Death	28a. Date of tnjury (Month, Day Year	W		c. Injury at Work?			ow injury occurred	opacity)
0	ittendin death. ctor: Aft / the fun	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year	) Injury	м	1 ☐ Yes 2	□No			
Division of Vital	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - A building, etc. (Spe		reet, lactory,	office		28f. Location (St. City or Town		or Rural Route Number,
0	rs after or serious and seriou	Cer	A	32.00.10.10				-			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai	(Check only 2 Medical Exam	ysician: To the best of my liner: On the basis of exam	knowledge, deat	h occurred at	t the time, date	and place, death occur	and due to the cared at the time, do	ause(s) and manne ate and place, and	er as stated. I due to the cause(s)
	To the hwithin 2. To the I	Med	one)	and manner stated.			License numbe				
	F 3 5 0		29b. Signature and title of certifier	e no			Coo s		_	9d. Date signed (A	
	15				1 00 \			1 07		6/10/	
	7.m		30. Name and address of person who		tem 23a) (Type,		Corlo	0/30	Pr. MA	9 17.22	27
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature	110		-401	110	2/6	0 6 6
		ar	IIIN 1	1 2007		· Ann	All a				

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Bessie Shaw News 2007 une /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salisbury Rehab 4 N 5. Social Security Number 6. Sex salisbur *vicomico* ursing Otr 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🐼 F 176-20-0609 7/9/1912 Pennsylvania Director Usual Residence of Decedent 10c. City. Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at 1 X Yes 2 ☐ No Director Wicomico Salisbury Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a or 2 iner must be n 403 Alabama Ave. 21801 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. "natural", or iten 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married white 1 ☐ Yes 2 🛛 No Specify: þ 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) Beautician Hair Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Amy Rowles James Bowers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 403 Alabama Ave., Salisbury, MD 21801 19a. Informant's Name/Relationship (Type. Print) Joan M. Brewington/daughter Department of Health a Important: If Item 27 is any injury or other tra once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Chester Rural Cemetery Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/12/07 Chester, PA 21. Signature of Funeral Service License 2HOTIOWAY Pureral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 well of 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** P &1-/Medical Due to (or as a consequence of) Examiner 010 C Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unkriown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 → No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an 1∏ Yes 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ⊟ Yes 2 ⊒∔Kб Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA

The law requires that the death certificate be executed burial-trar Division or Vital Records, P.O. Box 68760, attending physician the as signed by the atte certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Maryland 21215-0036

Baltimore,

show

27. Manner of Death

28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury

1 Natural 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 4 Homicide

1 ☐ Yes 2 ☐ No . Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

1 🖵 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner; stated.

29b. Signature and title of certifig 160

5 Pending

29d. Date signed (Month, Day, Year)

Registrar

Medical

Kobins, M. D 31. Date filed (Month, Day, Year)

JUN 1 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

**ORIGINAL** 

			For State Registrar		State	of Man	•	artment of ertificate of	Health and Death	Mental Hy	giene Reg. No.	Z U U /	20427
П			1. Decedent's Name (Fin	rst, Middle, La	st)					2. Date of De Month	aath Day	Year	3. Time of Death
	Physicia /Medic		Mae Even	a Osbo	rn					June			_0523M
	Examin		4a. Facility Name (If not			um <i>ber)</i>		4b. City, Town,	or Location of Dea			County of Dea	
			Glade Va	llev N	ursing	Cente	er	Walke	rsville		F	rederi	ck
	Funeral		5. Social Security Numb	er 6. S	өх		In yrs. last birthda	) If Under 1 Yea	r If Under 24 Hr		rth		thplace (State or Foreign ountry)
	Director		236-66-9	569	XM 2□F	96	Yrs.	Months Day	S Hours Mir	Sept.10			st Virginia
	D		Usual Residence of Dec										
	rylar how	ايا		b. County	_	10	Oc. City, Town or I						10d. Inside City Limits
	e-f	cto	MD F	rederi	2K	ļ	Walkers	ille					1  Yes 2 No
	th th	Director	10e. Street and Number		: -1- C+			10f. Zip Code			7	zen of What C	ountry?
	11 w	ai	56 West	rreder.	ick Str	eet		217	93		υ.	S.A.	
	dea sing	Funerai	11. Maritaf Status		12. Was Dec		er in U.S. 13	. Was Decedent of	Hispanic Origin? ( ban, Mexican, Pue	(Specify Yes or North Rican, etc.)	0-	14. Race - Am-	
0	afte or It	F	1 Never Married	_	1 ☐ Yes If Yes, G	2 X No		1 ☐ Yes 2 N			į	Specify: WI	
2-003e	within 72 hours after death with the Maryland ene. then "netural", or Items 23a or 28a-f ehow the Mudical Exama'rat must be notified at	d by	3 XWidowed 4 □	Divorced	Year or	Dates:							
ក	72 t	Completed	15. (Specify o	Decedent's E only highest gra	ducation i <i>de completed</i>	)	(Giv	edent's Usuaf Occi e kind of work don	e during most of w	orking	16b. Ki	nd of Business	/Industry
7	Aithin hear	ш	Elementary/Secondar		College	(1-4or 5+)		DO NOT use retir	90)				
Z	lled v lygie her t		8th grade 17. Father's Name (First		1		пс	memaker	19 Mother's N	ame (First, Middle		ne	
yland	be find the dot	Be		ewton							, MAIOGII	Julianie)	
Ž	J Mer Dark	ဥ			T D		405 14			Evans	0.	- T Ct- t-	Zi- Codel
20	12 st h and 7 te n traun		19a. Informant's Name/ Mrs. Martl			ter			etand Number or F Bay Driv				
a)	1 and 18alti em 27		20a. Method of Dispositi	<u>-</u>	- Daugii				-	Date		cation - City or	
<u> </u>	r of h		1 ◯XBurial 2 □ Cr	remation 3		n State	20b. Place of Disposemetery, cr	ematory or other p	dens 6-1			derickn	
	tant:		4 Donation 5										
Baitimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-1 show appriantly or other traumatic event, the Mudical Examination must be notified at Once.		21. Signature of Finera	I Salvice Lice	2500	Vis			DATLEY 8				
	20204		23a. Part1. Enter the di	V	nous	7			in Street			d. 2178	Approximate
			shock, or heart fail	ilure. List only	one cause on	each line	n not e				irrest,		Interval Between Onset and Death
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	/Medical Examiner		resulting in death)	•	Due to	o (or as a c	consequence of):						Jan
		-	Sequentially list condition if any, leading to immediate	ons,	b								
	ed sit	Examiner	cause. Enter Underlyin Cause (Disease or injur	diate	Due to	o (or as a c	consequence of):						
	end Fran	хап	that initiated events resulting in death) Last		C	o (or as a c	consequence of):						
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Q/Q	physi the	dlcal		•	d								
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j	the de	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□ Unk		ne of death 5	Other (specify)					
7.	that the by detac		Part IL Other significan	nt conditions	contributing to	deati but r	not resulting in the	underlying cause o	iven in Part I.	23e. Did	tobacco u	ise contribute t	to the cause of death?
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	sician: The law certificate has t irector, page 2 s	Š								1 ☐ Yes	ormed2 2 No	death?	s 2 No
VITAI	Physician: r this certific ral director,	Be	25. Was case referred t	to medical					-	eath (Check only	one)		
5	hysi his c	ဥ	1 ☐ Yes 2 No			Inpatient	2 ER/Outpati	ent 3 DOA		Home 5 ☐ Res			ecify)
	D 0 0	ü	27. Manger of Death  1. Natural 5	Pending	28a. Date (Mo	e of Injury onth, Day Y	'ear) 28b. Time fn <sub>f</sub> ury	W		28d. Describe	how infur	y occurred	
Sion	Attending ir death. ector: After by the fune	cat	2 Accident	investigatio					☐Yes 2☐No				
	irect	Certification:	3 Suicide 6 4 Homicide	determined	280. Piac	ce of Injury ding, etc. (	- At home, farm, : (Specify)	treet, factory, offic	8	28f. Location City or To	(Street an own, State	d Number or F )	Rural Route Number,
_	ital c irs af ral D			/									
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Att completely filled in by the fun	Medicai	29a. Certifier 1 (Check only 2 one)	Certifying Pl Medical Exa	niner: On the	basis of ex	xamination and/or	ath occurred at the investigation, in my	time, date and pla opinion, death oc	ce, and due to the curred at the time	cause(s) , date and	and manner a I place, and du	s stated. e to the cause(s)
	ithin (	Mec	29b. Signature and title	of certifier	and ma	inner state	u.	29c. Lice	nse number	T	29d. Dat	te signed (Mon	ith, Day, Year)
	F ≥ F 8		A P.A.	6-				J.	2101	4	Tim	16 11	2.607
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1		- 7,5	3. Name and address	person who	CAN MC	) 01 0021	th (Item 23a) (Typ	TANKY	ALS	FOON	MI	) 21	107
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		1	For State Registrar	State of Maryla	-	artment of H			Reg. No	.00/	20428
Phys	ician	1	. Decedent's Name (First, Middle, Las	•				2. Date of De Month	Da		3. Time of Death
	dical		Helen Elizabeth		<u> </u>	1		June 1	_	2007	12:25 p <sup>M</sup>
Exan	niner	4:	a. Facility Name (If not institution, give				r Location of Death		40	County of Deat	
		5	Julia Manor Head Social Security Number 6. Se		s. last birthday	Hagers If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	Washin	
Funer Directo				☐ M 2 🖾 F	82 Yrs.	Months Days	Hours Min.	Nov. 8	ay, Year,	924 Ma	hplace (State or Foreign untry) ryland
/land		-	0a. State 10b. County	10c. C	ity, Town or L	ocation					10d. Inside City Limits
Many if sh	ģ	N	Maryland Washi	ngton I	Hagerst	own					1 ☐ Yes 2 X No
h the	Director	$\vdash$	0e. Street and Number			10f. Zip Code			10g. Ci	itizen of What Co	untry?
h wit 23a o			1042 Mt. Aetna	Road		21740			Į	JSA	
deat	Funerai	1	1. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.		lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No		14. Race - Ame Black, White	
Baltimore, Maryland 21215-0036 sernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygene. mportent: if item 27 is marked other than "naturel", or Items 23e or 28a-f show my injury or other treumatic event, the Mcdcal Examiner must be notified at	þ		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ★No If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No		Tribati, oto.)		Specify: Whi	
5-0 72 ho	Completed		15. Decedent's Ed (Specify only highest gra	ucation	16a. Dece	dent's Usual Occup	eation	ina	16b. k	Kind of Business/	Industry
21215-0 4 within 72 hc giene. r than "natur The Mcdical	a de	-	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	during most of work d)	y			
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Via Menia Menia arke	은		Samuel Royer	. (22, 5-			Helen R	loyer			
2 shot and is m			19a. Informant's Name/Relationship (1	Гуре, Print)	19b. Maili	ng Address (Street	and Number or Rura	al Route Numb	er, City	or Town, State, Z	Zip Code)
re, M s 1 and 2 f Health item 27 i		_	Kathy Stenger/Gra				oad, Wayn				
Ore pes 1 of H if iten		2	0a. Method of Disposition 1   ■ Burial 2 □ Cremation 3 □		Place of Dispersion of Dispers	osition (Name of matory or other place	ce)	Date	20c. L	ocation - City or	Town, State
Baltimore, Permit. Pages 1 and Department of Healtl Importent: If item 27 any injury or other 1			`4 □Donation 5 □Other (Specify	)	Rest Ha	ven Cemet	tery 6/22,	/2007	Hag	gerstown	, Maryland
salt.	9	2	21. Signature of Funeral Service Licen	S99	2	2. Name and Addre	ss of Facility Res	st Have	n Fu	ıneral C	hapel
m %0E%	a		23a. Part1. Enter the disease, or compshock, or heart failure. List only	upp			sylvania A			gerstown	Md 21742
Pyco, Medica Examine Examine physician and physician and the burial-transit	Examiner	t	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, farry, Learn 3 to inherenate cause. Enter Underlying Cause (Disease or injury hat initiated events resulting in death) Last	b. Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.	re	ary H	ypertec m	NIJE.	«>~		
Division of Vital Records, P.O. Box 68760, 37  To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	1 3	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	□Ectopic pregnancy □ Other (specify) _	,			23d. Date of del Month	ivery Day Year
S, F res tha igned l	þ	P	Part II. Other significant conditions of	1	esulting in the i		en in Part I.				the cause of death?
cord v requir been s should	ted	-	Diak	octes Me	111110	·)			Yes 2	2 □ No 3 □ Pr	obably 4 Unknown
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/ita	Be	2	25. Was case referred to medical examiner?				26. Place of Deat				
of V Physic this ce	2		1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	nt 3 DOA Oth	ner: 4 Jursing Ho	me 5 Res	idence	6 ☐Other (Spe	city)
ion o nding Pt ath. r: After the		2	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	of 28c. Injur Wor	v at	28d. Describe			
Division of the or attention state death of Director:	Certification:		3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec		reet, factory, office		28f. Location ( City or To	(Street a iwn, Stai	and Number or Ru te)	ural Route Number,
Division of Vital Ru To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the tuneral director, page	edical (		29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of my kininer: On the basis of examinand manner stated.	nowledge, dea nation and/or in	th occurred at the til evestigation, in my o	me, date and place, opinion, death occur	and due to the red at the time	cause( , date ar	s) and manner as nd place, and due	s stated. to the cause(s)
To ti Vithii To th	Σ		29b. Signature and title of certifier	. L. A		29c. Licens				ate signed (Mont	rh-
			Jany V	men		DO	60396		0	6/19/	0)
\"	7	;	30. Name and address of person who	completed cause of death (It	em 23a) (Type	, Print)	1126	opal	C	t	1740
	State strar		31. Date filed (MOUN 2 Year) 200	32. Registrar's Sig	nature	des	Exelore	(00-1	1	( 1 m s)	

	-	For State Registrar	i State of Wa		partment of fartificate of			giene	07 20429		
								Date of Death Month Day Year  3. Time of Death			
Physicia /Medic	_	MARY ELIZABETH PHEULPIN						JUNE 18,2007 7,451			
Examin	_	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death	1	4c. County	of Death		
	2. 2	CHAS.CO.NUR.&	REHAB.CE	NTER	I.A.	PLATA If Under 24 Hrs.			RLES		
Funeral		5. Social Security Number 6. Se		e (In yrs. last birtho	Months Days	Ti Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th y, Year)	Birthplace (State or Foreign Country)		
Director		0.5 00 000	□ M 2 X F	78 Yrs	š.		DEC.6	1928	MD.		
and	1	Usual Residence of Decedent  10a. State 10b. County p	revard	10c. City, Town o	r Location				10d. Inside City Limits		
Manyl f eho	0	FL. CHARLE	<del>C</del>		LA PLATA	_ Palm	Bay		X Yes 2 No		
the 1	Director	40 - Chart and N. mbar	11.1 0		10f. Zip Code	32907		10g. Citizen of W	/hat Country?		
3 with		1/96 B	dith Stree	et NE	- 21	32507		U.S.A.			
death ma 2	Funeral	11. Marital Status	12. Was Decedent I	Ever in U.S.	13. Was Decedent of H		pecify Yes or No		- American Indian,		
ING 21215-UU36  be filed within 72 hours after death with the Maryland ital Hygiene. In Inygiene. In other than "natural", or Items 23s or 28e-f ehow event, the Medical Examinating the notilised at		1 Never Married 2 Married	Armed Forces?  1  Yes 2 If Yes, Give	10	1 ☐ Yes 2 ☐ No	an, Mexican, Puerti Specify:	o Hican, etc.)		k, White, etc.		
Z 1 Z 1 S-0036 d within 72 hours af giene. r than "natural", or tre Medical Exem	d by	3 ₩idowed 4 Divorced	Year or Dates:					Specify	WHITE		
72 h	Completed	15. Decedent's Ed (Specify only highest grad		(0	ecedent's Usual Occup Give kind of work done fe. DO NOT use retired	during most of wor	king	16b. Kind of Bu	siness/Industry		
within 72 ene.	шb	Elementary/Secondary (0-12)	College (1-4or 5	+)	HOMEMAKE			OWN H	OME		
Hygie other mut, w		12th 17. Father's Name (First, Middle, Last)			HOMEMAKE		ne (First, Middle	Maiden Sumam			
Maryland d 2 should be file th and Mental Hy traumatic event	Be c	WILLIAM LESI	TE DIDDO	HCHC				INE HIG	•		
re, Narylan s 1 and 2 should be f Health and Menta ttam 27 le marked other traumatic ev	은	19a. Informant's Name/Relationship (7			lailing Address (Street						
		LAURENT PHEULP			1 SASSAF						
re, N s 1 and s if Health Item 27 other tr		20a. Method of Disposition		20b. Place of D	isposition (Name of		Date		City or Town, State		
Baltimor permit. Pages Department of Important: If its any injury or o		Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		The second second	crematory or other pla		3-07	ALM BA	Y.FLA.		
Baltimore, permit. Pages 1 ar Department of Hea Important: if itam: any injury or other once.	Ηĝ	21. Signature of Fureral Service Licen:	77.01	_					,		
Balt permit. Departr Import		me. O.	0	1	PAYMOND I RAYMOND I LA PLATA	FUNERAL	SERVIO	CE, P.A.			
8, 11, 8,		23a. Part1. Enter the disease, or comp	lications that caused	the death. Do no				rrest,	Approximate Interval Between		
Physician		shock, or heart failure. List only of Immediate Cause (Final		- 1	000		,		Onset and Death		
Physician /Medical		disease or condition resulting in death)	a. Terry	a consequence of)		mon	14	-	3 days		
Examiner				a vonsoquence on							
	Jer	Sequentially list conditions, if any, leading to anneoliate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of)							
60,4 be executed sicien and burial-transit	Examiner	Cause (Disease or injury that initiated events	C								
O See											
18760, L	dlcal		d								
ng pt	Med	IF FEMALE:									
BOX sath cer attendir for use	an/I	23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		23d. Dat Mor	te of delivery nth Day Year					
O. E e dea the at	sicl	in the past 12 months? 1 □ Yes 2 No	4□Pregnant at 9□Unknown	time of death	5 Other (specify)	-		Moi	IIII Day (6a)		
Records, P.O. Box 6 The law requires that the death certificate has been signed by the attending; bage 2 should be detached for use as	Physiclan/Me	9 Unknown				i- D	oo- Did	tabaasa waa aast	chute to the pourse of death?		
Cords, F w requires tha been signed to should be det	þ	Part II. Other significant conditions co		23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown							
Orc requi	ted						''	Tes ZMNO	3 Probably 4 Orikilowii		
Recamber of the second	nple						24a. Was	psy p	Were autopsy findings available prior to completion of cause of		
The cate h	Completed						1 Yes		death? I□Yes 2□No		
Vital Fidelericien: The certificate	Be	25. Was case referred to medical examiner?	Hoopital:		0.00		ath (Check only				
Of Of Othysic this cal direction	은	1 163 5 200	Hospital: 1 Inpatie		atient 3L DOA			idence 6 Oth			
Vision of Vita Attending Physicien: oftor: After this certific by the funeral director,	o	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Tin Inju	ıry Wo	ryat rk? ]Yes 2 □No	28d. Describe	how injury occurr	ed		
ISIC tor:	cat	2 Accident investigation 3 Suicide 6 Could not be		uny - At homo fara		] 165 2   140	28f Location	(Street and Numb	er or Rural Route Number.		
Division of Vital Records, for Attending Physicien: The law requires that death. Director: After this certificate has been signed in by the funeral director, page 2 should be controlled.	Certification:	4 Homicide determined	building, et	c. (Specify)	n, street, factory, office			wn, State)	or or ribrar rioble reprider,		
pital ours erel		29a. Certifier  (Check only  2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
Division of Vital Re Nothin 24 hours after death.  To the Hospital or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only 2 Madical Examone)	iner: On the basis o	f examination and/ ated.	or investigation, in my	opinion, death occu	irred at the time	date and place,	and due to the cause(s)		
To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed	d (Month, Day, Year)		
L > F 0		1. F. Okem, MO 055455						6/19/07			
		30. Name and address of person who	completed cause of c	leath (Item 23a) (T		0 10		-//	///		
Q		FATIMA HUSSEIN				Cittura	101 023	"D CD	NGC N		
Sta	ate	31. Date filed (Month, Day; Year)	32 Registr		TOWN RD.	OULIE	TUT CAL	TY SPKI	MG2,MD		
Regist	rar	JUN 2 5 201	17 Glave	J. 1. 14	barle						
DHMH 17 Rev 1/2	001										

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

1 1 2007

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Mar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 20431

Marque Anthony Qu	1- For State Of Wallyland / Department of Fredak and Inches of Death	Reg. No.									
	Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of Death Month Day Year 1443 hrs									
Me Examiner	Margue ANDONCE WHOON	June 8, 2007									
	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of De Union Hospital	Cecil									
	15. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	- IForeign A 4 V									
Funeral Director	211-27-1214 1X M 2 F /5 Yrs. Months Days Hours N	vin. 1-24-1992 country) MD									
	Usual Residence of Decedent	10d. Inside City Limits									
any	10a. State 10b. County 10c. City, Town or Location	1 Yes 2 No									
land f show	M)   CL/   VORTINGS	10g. Citizen of What Country?									
the Maryland a or 28a-f sh tiffed at onc	10e. Street and Number  21901	USA									
ith the 123a o	11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?  Armed Forces?	( Specify Yes or No- erto Rican etc.) 14. Race - American Indian, Black, White, etc.									
r death with or items 23 must be no	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	Specify: Black									
s after d ral", or	3 Wildowed 4 Divolocal or Dates:										
hours natur Exami	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give Kind during most of working life. DO NOT use during most of working life. DO NOT use	e retired)									
36 nin 72 than " tdical	Student	STUCIENT									
5-0036 led within 72 hour Hygiene. I other than "natur the Medical Exan Completed	17. Father's Name (First, Middle, Last)	lame (First, Middle, Maiden Surname)									
121 I be fill ental I arked vent,		r or Rural Route Number, City or Town, State, Zip Code)									
MD 21215-0 d 2 should be filed w the and Mental Hygi nn 27 is marked oth aumatic event, the L To Be Co	Lating & Nannis 1/0 adal AMILL	RUO, NORTHWOST MD 21901									
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 hours after death with the Maryland and Health and Mental Hygene. It filean 21's marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State									
more ages 1 ages 1 int: If	1 Burial 2 Cremation 3 Removal Holli State Way on St Unotifu	6-15-07 NORTHOOST, N.D.									
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she important: If item 27 is marked other than "natural", or items 23a or 28a-f she import or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	21. Signature of Funeral Service Licensee	Lucial dada Davido No									
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as card	diac or respiratory arrest, shock, or heart Between Onset and									
hysician Medical	failure. List only one cause of each file.	Death									
Examiner	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):										
	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):										
	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated  C.  Due to (or as a consequence of):  Due to (or as a consequence of):										
ed Insit	events resulting in death) Last										
ox 68760, eath certificate be executed a attending physician and for use as the burial - transit	d.  UNPENDED AMENDED										
60, ate be o	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery  Month Day Year									
687 certifica nding pl	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic 4 Pregnant at time of death 5 Other (Specify)	pregnancy									
Box e death c the atten	1 Yes 2 No 9 Unknown g Unknown	t I. 23e. Did tobacco use contribute to the cause of death?									
O. Bo at the de d by the		1 Yes 2 No 3 Probably 4 Unknown									
ires that the is signed by to do be detache	Aq	24a. Was an 24b. Were autopsy findings available									
ords, w requir	ompleted	autopsy prior to completion of cause of death?									
Recol The law cate has		Tes 2 No Tes 2									
Vital Recysician: The I	25. Was case referred to medical examiner?   Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other	Nursing Home 5 Residence 6 Other:									
Sion of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be releath evertificate has been signed by the attending physici by the funeral director, page 2 should be detached for use as the burn by the funeral director, page 2 should be detached for use as the burn by	1 Ves 2 No 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work	? 28d. Describe how injury occurred Subject drowned									
on of \number of \numb	27. Manner of Deall 5 Pending FOUND: 1 Yes 2 ✓ 1 Natural 5 Pending Jun 8, 2007 1346 hrs	No State City									
Division pital or Attendi ours after death	28e. Place of Injury - At home, farm, street, factory, office building, et	c. 28f. Location (Street and Number or Rural Route Number, City or Town, State) North East River, North East, MD									
Div	the state and place, and due to the cause(s) and manner as stated.										
Division To the Hospital or Attendit within 24 hours after death To the Funeral Director: A completely filled in by the fi	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plat one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and plat one)  4 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plat of the	Confed at the time, the confederation of the confed									
Totl Totl Comp	Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death ocone)  29b. Signature and title of certifier  29c. License number	29d. Date signed (Month, Day, Year)									
-	Downto with II MI)	June 9, 2007									
2	30. Name and duess of person who completed cause of death (Item 23a)  Republic F. Sputhall MD. Assistant Medical Examiner 111 Penn Street, Baltin	pare MD 21201									
m 2	Pamela E. Sputhall, MD Assistant Medical Examiner 111 Penn Street, Baltin	IDIO, IND A IDO									
St	are that 1 4 2007 to be										

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar		State of M	arylariu /		rtificate of		ariu ivie		Reg. No.	2007	20432	
Physic		an	1. Decedent's Name (F		,					2	2. Date of Dea Month <b>June</b>	ath Day <b>6</b>	Year <b>2007</b>	3. Time of Death  3:30 p <sup>M</sup>	
	/Medic	2007	Mary Victoria Russo					4b. City, Town, o	r Location of	of Death	Julie		ounty of Death	3:30 р	
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, To  3605 Dunnington Road						Beltsvi					ge's	
	Funeral	ş- 4	5. Social Security Num			ge (In yrs. last	rs. last birthday) If Under 1 Year   If Under 24			B. Date of Birt			place (State or Foreign		
4	Director		579-48-0619	9	☐ M 2 <b>X</b> F	74	Yrs.	Months Days	Hours	IVIII1.				Italy	
	and w	tor	Usual Residence of De 10a. State 10	ecedent 0b. County		10c. City, T	own or Lo	cation					1	0d. Inside City Limits	
	Marylan f show led at									1 ☑ Yes 2 ☐ No					
	r 28a	irec	10e. Street and Number		0180 0	1		10f. Zip Code				10g. Citize	en of What Cour	ntry?	
	th with	a D	3605 Dt	unnington	Road			20	705				U.S.A.		
e, Marylan	r dear	Funeral Director	11. Marital Status		12. Was Decedent Armed Forces	?	13.	Was Decedent of I If Yes, specify Cub	lispanic Ori an, Mexica	igin? (Spec n, Puerto R	ify Yes or No lican, etc.)	. 14	<ol> <li>Race - Americ Black, White,</li> </ol>		
	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Fi	1 ☐ Never Married 2 【 Married 1 ☐ Yes 2 】 If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates			1 ☐ Yes 2 🗷 No Specify:					s	Specify: Caucasian			
	2 hour atural cal Ex	ed	15. Decedent's Education 16a. Decedent's Usual Occupation					16b. Kind of Business/Industry							
	thin 7; e. an "n Medi	ple	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of wo						st of Working						
	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the M	Be Completed	8 Seamstress					Ala	Retail Clothing ne (First, Middle, Maiden Surname)						
	ould be fil Mental H arked oth atic even		17. Father's Name (Fin		)				1						
	should and Men s marke umatic	ဥ	John Car		Type. Print)		19b. Mailir	na Address (Street			r Caputo ural Route Number, City or Town, State, Zip Code)				
	nd 2 s Ith an 27 is i			usso - Hu				Dunnington						,	
	is 1 and 2 of Health Item 27 i		20a. Method of Dispos	sition	18	20b. Plac	e of Dispo	osition (Name of matory or other pla	1		ate		ation - City or To	own, State	
	Page nent c		1 <b>x</b> Burial 2 □0 4 □ Donation 5		Removal from State fy)		of He	eaven Cemet	ery	6/11/	2007	Si1v	er Spring	g, Maryland	
	permit. Pages 1 and Department of Health Important: if Item 27 any Injury or other tr		21. Signature of Fune	eral Service Lice	nsee		22 <b>H</b>	2. Name and Addre ines-Rinalo	ess of Facili	ral Ho	me, Inc.				
	20 E % 0		11800 New Hampshire Avenue, Silver Spring, Maryland 20904										yland 20904 Approximate		
			shock, or heart fill Immediate Cause (Fir	failure. List only	one cause on each	ine.	Do not em	ter the mode of dyn	ng, such as	cardiac or	теѕрпатогу а	nesi,		Interval Between Onset and Death	
	Physician /Medical	П	disease or condition resulting in death)	iai	a.	Carcinon s a consequen									
	Examiner	ner				e Carcin									
			Sequentially list conditions b.												
	ecuted nd transi	Examiner	Cause (Disease or injust that initiated events resulting in death) Las	üry											
60,	icate be executed physician and s the burial-transit	E E	resulting in death) Last Due to (or as a consequence of):												
68760,	ificate be executed g physician and as the burial-transit	edical	d												
		/Me	IF FEMALE: 23b. Was decedent p	regnant		23c. If yes, outcome pf pregnancy					23	3d. Date of deliv	ate of delivery		
Box	death atter	iciar	in the past 12 months?  1 □ Voc. 2 □ No.  4 □ Pregnant at time of death 5 □ Other (specify)						у				Month Day Year		
P.0	at the by the tache	Physician/M	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
	w requires that the death cer been signed by the attendin should be detached for use									I.	23e. Did tobacco use contribute to the cause of dea				
Records,	requir een s hould	sted													
3ec	e law has b je 2 sk	o Be Completed by									24a. Was auto		24b. Were auto prior to co death?	opsy findings available ompletion of cause of	
a	n: The ficate har, r, page		25. Was case referred	d to modical					OC Diag	a of Dooth	1□ Yes	2 🗓 No	1 ☐ Yes	2□No	
or Vital	Physician: this certific ral director,		examiner? 1 ☐ Yes 2 🕱 No	Pr? Hospital: Other:									(fv)		
0	g Phy ter this seral c	n: To	Long Data of Liver Long Time of Long Liver								28d. Describe how injury occurred				
Division	Attending r death. ector: After by the fune	atio	1   X Natural   5   Pending   (Montal, Day Year)												
<u>\S</u>	or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide	determined	Zoe. Flace of I	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			2	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	pital ours af	Medical Cer										stated.			
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		2d. Certifier Check only one)    Check only one   Check												
	To the within To the Comple	Me	29b. Signature and ti	le of certifier	11.0	0		29c. Licen	se number			29d. Date	signed (Month)	, Day, Year)	
	2(3)		▶ W	7	vinal			D	45285			Ju	ne 7, 200	7	
			30. Name and address						C	112 0	Wilmen C	nwi	Marrel and	2000]	
	*		Wilkinson 31. Date filed (Month,		Ninala, M.D.				Suite	ш, 5	oriver 2	pring,	marytand	ZU7UL	
Æ	St: Regist	ate rar	JUN	0 0 00		trar's Signatur	60	W.							

DHMH 17 Rev 1/2001

Willard Archie Reynolds   Sr.   4b. City, Town, or Location of Death   4c. County of	9. Birthplace (State or Foreign Country)  Delaware  10d. Inside City Limits 1  Yes 2 No  That Country?  - American Indian, (White, etc.  White siness/Industry  Ction  9)
Willard Archie Reynolds   Sr.   4b. City, Town, or Location of Death   4c. County of	4:21 A  of Death  CO  9. Birthplace (State or Foreign Country)  Delaware  10d. Inside City Limits 1  Yes 2 M No  That Country?  - American Indian, 6, White siness/Industry  Ction  State, Zip Code) rings, MD 21837
23626 East Hurleys Neck Rd.  S. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year in Under 24 Hrs. (Month, Day. Year) 12/6/1928  Jone 1 10 1 10 1 10 1 10 1 10 1 10 1 10 1	9. Birthplace (State or Foreign Country)  Delaware  10d. Inside City Limits 1  Yes 2 M No  That Country?  - American Indian, (, White, etc.  White siness/Industry  Ction  State, Zip Code) rings, MD 21837
Social Security Number   5. Social Security Number   5. Social Security Number   222-16-8307   18 M 2 F   7. Age (In yrs. last birthday)   78 Yrs.   11 Under 1 Year   11 Unde	9. Birthplace (State or Foreign Country)  10d. Inside City Limits 1  Yes 2  No  That Country?  - American Indian, (, White, etc.  White siness/Industry  Ction  3)  State, Zip Code) rings, MD 21837
Director  Mardela Springs  Director  Mardela Springs  Director  Director  Director  Mardela Springs  Director  Director  Director  Director  Director  Director  Director  Mardela Springs  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Director  Mardela Springs  Director  Director  Director  Director  Director  Director  Mardela Springs  Director  Director  Director  Director  Director  Director  Director  Director  Mardela Springs  Director  Directo	Country) Delaware  10d. Inside City Limits 1
Usual Residence of Decedent  10a. State  10b. County  Maryland  10c. City, Town or Location  Maryland  10c. City, Town or Location  Maryland  10d. State  10d. Street and Number  23626 East Hurleys Neck Rd.  11. Marital Status  12. Was Decedent Ever in U.S.  11. Marital Status  12. Was Decedent of Hispanic Origin? (Specify Yes or No-Black Black Synchry)  12. Was Decedent of Hispanic Origin? (Specify Yes or No-Black Synchry)  12. Was Decedent of Hispanic Origin? (Specify Yes or No-Black Black Synchry)  12. Was Decedent of Hispanic Origin? (Specify Yes or No-Black Black Synchry)  12. Was Decedent of Hispanic Origin? (Specify Yes or No-Black Black Synchry)  12. Was Decedent of Hispanic Origin? (Specify Yes or No-Black Black Synchry)  12. Was Decedent of Hispanic Origin? (Specify Yes or No-Black Black Synchry)  12. Was Decedent of Hispanic Origin? (Specify Yes or No-Black Black Synchry)  12. Was Decedent of Hispanic Origin? (Specify Yes or No-Black Black Synchry)  12. Was Decedent of Hispanic Origin? (Specify Yes or No-Black Black Synchry)  12. Was Decedent of Hispanic Origin? (Specify Yes or No-Black Black Synchry)  12. Was Decedent of Hispanic Origin? (Specify Yes or No-Black Black Synchry)  12. Was Decedent of Hispanic Origin? (Specify Yes or No-Black Black Synchry)  12. Was Decedent of Hispanic Origin? (Specify Yes or No-Black Black Synchry)  12. Was Decedent of Hispanic Origin? (Specify Yes or No-Black Black Synchry)  12. Was Decedent of Hispanic Origin? (Specify Yes or No-Black Black Synchry)  12. Was Decedent of Hispanic Origin? (Specify Yes or No-Black Black Synchry)  13. Was Decedent of Hispanic Origin? (Specify Yes or No-Black Black Synchry)  14. Race Black Synchry  15. Decedents Usual Occupation  (Give kind of work done during most of working life. Do NoT use retired)  16a. Decedents Usual Occupation  (Give kind of work done during most of working life. Do NoT use retired)  17. Father's Name (First, Middle, Last)  18a. Mother's Name (First, Middle, Maiden Synchry)  18b. Mailing Address (Street and Number	10d. Inside City Limits  1 □ Yes 2 🖾 No  That Country?  - American Indian, (, White siness/Industry  Ction  State, Zip Code) rings, MD 21837
10a. State   10b. County   10c. City, Town or Location   Maryland   Wicomico   10c. City, Town or Location   Maryland   Wicomico   10c. City, Town or Location   Maryland   Wicomico   10c. City, Town or Location   Maryland   Wicomico   10c. City, Town or Location   Maryland   Wicomico   10c. City, Town or Location   Maryland   Springs   10c. City, Town or Location   Maryland   Springs   10c. City, Town or Location   Maryland   Springs   10c. City, Town or Location   Maryland   Springs   10c. City, Town or Location   Maryland   Springs   10c. City, Town or Location   Maryland   Springs   10c. City, Town or Location   Maryland   Springs   10c. City, Town or Location   Maryland   Springs   10c. City, Town or Location   Maryland   Springs   10c. City, Town or Location   Maryland   Springs   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City, Town or Location   10c. City Town of Wardela Springs   10c. City Town of Wardela Springs   10c. City Town of Wardela Springs   10c. City Town of Wardela Springs   10c. City Town of Wardela Springs   10c. City Town or United   10c. City Town of Wardela Springs   10c. City Town of Wardela Springs   10c. City Town of Wardela Springs   10c. City Town of Wardela Springs   10c. City Town of Wardela Springs   10c. City Town of Wardela Springs   10c. City Town of Wardela Springs   10c. City Town of Wardela Springs   10c. City Town of Wardela Springs   10c. City Town of Wardela Springs   10c. City Town of Wardela Springs   10c. City Town of Wardela Springs   10c. City Town of Wardela Springs   10c. City Town of Wardela Springs   10c. City Town of Wardela Springs   10c. City Town of Wardela Springs   10c. City Town	Intervention Indian, white siness/Industry  Ction  State, Zip Code)  rings, MD 21837
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Charles Daniel Reynolds    Policy   Pol	s) State, Zip Code) rings,MD 21837
Charles Daniel Reynolds    Policy   Pol	rings,MD 21837
Willard Reynolds Jr/son  23624 E. Hurleys Neck Rd., Mardela Spinology  20a. Method of Disposition  1  Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Holloway Funeral Home P.A.  501 Snow Hill Rd. Salisbury, Maryla  23a. Part 1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,	rings,MD 21837
Athol Baptist Church  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Holloway Funeral Home P.A.  501 Snow Hill Rd. Salisbury, Maryla  23a. Part1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,	
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m a a g a g a g a g a g a g a g a g a g	Springs,Marylan
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,	and 21804
shock, or heart failure. List only one cause on each line.	Approximate Interval Between
Physician Immediate Cause (Final disease or condition	Onset and Death
/Medical resulting in death)  Due to (or as a consequence of):	
Examiner . Sequentially list conditions b.	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couco, Dispace or knjis, y	j
if any, leading to immediate cause. Enter Underlying Cause (Die ass a right) that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	=
Due to (or as a consequence of):    Cause. Enter Underlying Course (Die and or high) that initiated events resulting in death) Last   Cause. Enter Underlying Course (Die and or high) that initiated events resulting in death) Last   Due to (or as a consequence of):    Due to (or as a consequence of):	
Spoon of the past 12 months?  The past 12 months?	
FFEMALE:   23c. If yes, outcome of pregnancy   23d. Date   23d.	of delivery
The past 12 months?  1 □ Ves 2 □ No  1 □ Ves 2 □ No  1 □ Ves 2 □ No  1 □ Ves 2 □ No  1 □ Ves 2 □ No  1 □ Ves 2 □ No	
o and the second of the second	
1   Yes 2   No 9   Unknown 9   Unknown 9   Unknown 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.	bute to the cause of death?
Hecords 2	3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy pr	Vere autopsy findings available rior to completion of cause of
24a. Was an autopsy performed? In yes 20 No 11	eath?
Performed?  25. Was case referred to medical examiner?  1 Yes 2 No 1  25. Was case referred to medical examiner?  1 Yes 2 No 1  26. Place of Death (Check only one)  1 Yes 2 No 1  27. Manner of Death 1 Natural 5 Pending (Month, Day Year)  28a. Date of Injury Work?  M 1 Yes 2 No 2  28b. Time of Injury Work?  M 1 Yes 2 No 2  28c. Injury at Work?  M 1 Yes 2 No 2  28d. Describe how injury occurred to medical examiner?  Month, Day Year)  28d. Describe how injury occurred to medical examiner?  1 Yes 2 No 2  28d. Describe how injury occurred to medical examiner?  1 Yes 2 No 2  28d. Describe how injury occurred to medical examiner?  1 Yes 2 No 2  28d. Describe how injury occurred to medical examiner?  1 Yes 2 No 2  28d. Describe how injury occurred to medical examiner?  1 Yes 2 No 2  28d. Describe how injury occurred to medical examiner?  1 Yes 2 No 2  28d. Describe how injury occurred to medical examiner?  1 Yes 2 No 2  28d. Describe how injury occurred to medical examiner?  M 1 Yes 2 No 2  28d. Describe how injury occurred to medical examiner?  M 1 Yes 2 No 2  28d. Describe how injury occurred to medical examiner?  M 1 Yes 2 No 2  28d. Describe how injury occurred to medical examiner?  M 1 Yes 2 No 2  28d. Describe how injury occurred to medical examiner?  M 1 Yes 2 No 2  28d. Describe how injury occurred to medical examiner?  M 1 Yes 2 No 2  28d. Describe how injury occurred to medical examiner?  M 1 Yes 2 No 2  28d. Describe how injury occurred to medical examiner?  M 1 Yes 2 No 2  28d. Describe how injury occurred to medical examiner?	
25. Was case referred to medical examiner?  1  Yes 2 No	
27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurre	ed by
To the strict of	
To be the composition of the com	r or Hurai Houte Number,
29a. Certifier  (Check only only only only only only only only	oner as stated
28e. Place of Injury - At home, farm, street, factory, office  28f. Location (Street and Number City or Town, State)  28e. Place of Injury - At home, farm, street, factory, office  28f. Location (Street and Number City or Town, State)  28f. Location (Street and Number City or Town, State)  28f. Location (Street and Number City or Town, State)  28f. Location (Street and Number City or Town, State)  28f. Location (Street and Number City or Town, State)  28f. Location (Street and Number City or Town, State)	
and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed	
	(Month, Day, Year)
Hintico (194)	(Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	(Month, Day, Year)
	(Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	(Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 2:10 P.M 19,2007 Adolf R. Schwartz June /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Center Potomac Valley Nursing&Wellness Rockville
Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Yrs. 104 Director 058-07-5592 October 4,1902 New York Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State rthen "naturel", or itema 23a or 28e-f ehow the Medical Examinar must be notified at 10b. County Yes 2 No New York Nassau Freeport Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 11520 Beach Ave. death v 660 South Long Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. e filed within 72 hours after d if Hygiene. other then "naturel", or item 1 ☐ Yes at No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XNo Specify: ģ 3- Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Movie & Sound College (1-4or 5+) Elementary/Secondary (0-12) Equipment Self Employed Pages 1 and 2 should be filed witnest of Health and Mental Hygiestant: If Item 27 is marked other to jury or other treumatic event, ID 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kate Pick ျှ Morris Schwartz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 307 Leon's Legacy Court, Silver Spring MD. Toby Schwartz/Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Depertment important: If only injury or once. Ararat Cemetery 6/22/07 Farmingdale, NewYork 4 □Donation 5 □Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Marzullo Funeral Chapel, P.A. 6009 Harford Road Baltimore, Maryland 21214 Michael 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ven Physician /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires thet the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown been signed to should be deti-23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No s certificate has b irector, page 2 st autopsy 2 No 1 Tes the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 450 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No his After this funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation efter death Director: / 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours eft To the Funerel DI completely filled in 29a. Certifier 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of D0062435 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pers EISAYYAD Mich SATED 2. Registrar's Signature State JUN 2 5 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** A M 6 2007 3:53 10 Kathryn I. Staci /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Worcester Atlantic General Hospital Berlin If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🖸 F 88 6/24/1918 Director 184-01-7246 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County t of Health and Mental Hygiene.
If item 27 is marked other then "naturel", or items 23s or 28s-f show or other traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 ☑ No Director Pittsville Wicomico MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 33998 Middleton Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give<sup>2</sup> Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐kNo Specify: Specify: White Š 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accountant Accounting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event one. Catherine Gross William Loder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 33998 Middleton Rd., Pittsville, MD 21850 Fran Abruzzo / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ € remation 3 ☐ Removal from State Frankfod, DE 6/14/07 Cape Henlopen Crem. 4 ☐ Donation 5 ☐ Other (Specify) The Burbage Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 108 William St., Berlin, MD 21811 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis

Due to (or a va consequence of): Physician /Medical Examiner Incommia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Infection Urinary Tract Due to (or as a consequence of): Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by artery disease 1 Yes 2 No 3 Probably 4 Onknown 24a. Was an autopsy performed? 1 ☐ Yes 2 XNo 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No diverticulum Asthma of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ➤ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Division Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

Director: Aff 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 / Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29b. Signature and title of certifier H0064428 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9733 Healthway Drive Berlin, MD 21811 Jason Szymala, Do. Atlantic General Hospital 32. Begistrar's Signature 31. Date filed (Month, Day, Year) State JUN 1 1 2007 Registrar

MD

Year

ET 5+1 State

31. Date filed (Month, Day, Year)

JUN 1 1 2007

50. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MD 21801 32. Registrar's Signature

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State Registrar	State of Ma			tificate of I		лептат ну	'gien Reg. N		201	37
	Physici	an	1. Decedent's Name (First, Middle, La Chloe Elizabeth	,		-			2. Date of De Month	D	ay Year	3. Time of	
	/Medic Examir		4a. Facility Name (If not institution, giv				4b. City, Town, or	r Location of Death	June	$\frac{10}{4}$	2007 c. County of Deatl	]9:30a	M
	- Admin		6825 White Rock	Road			Sykesvi1	.1e			Carroll		
	Funeral Director			ex 7. Age	e (In yrs. last birth Y	rs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Jan 9	th ay, Yea 192	r) Coi	nplace (State or untry)	Foreign
	/land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Loc	ation	-				10d. Inside Cit	y Limits
	a-f sh	ctor	MD Carroll		Sykesvi	.11e						1 ☐ Yes	2 <b>X</b> No
	th with the 23a or 28 ust be no	<b>Funeral Director</b>	10e. Street and Number 6825 White Rock	Road			10f. Zip Code 21784			10g. C	Citizen of What Co	untry?	
21215-0036	be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ò	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Midowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1  Yes 2  Yes, Give X Year or Dates:			/as Decedent of H Yes, specify Cuba ☐ Yes 2☐XNo	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	)-	14. Race - Amer Black, White Specify: whi	, etc.	
15-0	יל 72 ה "natu edical	letec	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. [	Decede (Give k	ent's Usual Occup	ation during most of work f)	ing	16b.	Kind of Business/I	ndustry	
212	withir liene. r than the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5			kkeeper	1)		off	fice mana	gement	
Maryland 2	be od o	To Be C	17. Father's Name (First, Middle, Last Funkhouser	)				18. Mother's Nam	e (First, Middle cafton	, Maide	en Surname)		
	s 1 and 2 should if Health and Menitem 27 is marker other traumatic		19a. Informant's Name/Relationship (Deborah Winkler (1					and Number or Rui					
Baltimore,	age ento it: if y or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ⚠ Other (Special	Removal from State	T -1		ition (Name of atory or other place alley Ma	us. 6-12-	Date -07		Location - City or 1	•	
Balt	permit. Pag Departmen Important: any injury once.		21. Signature of Funeral Service Lice  Day Jaight 9			22. P.	Name and Address O. Box 1	<sup>ss of Facility</sup> Ha <b>i</b> 95 Sykesv	ght Fur ville, N	nera MD 2	1 Home & 21784	Chape1	
	Physician /Medical Examiner	ı.	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. B/a Due to (or as a	dder a consequence of	f):	r the mode of dyin		or respiratory a	rrest,		Approximate Interval Betw Onset and D	eath
68760,	tificate be executed ig physician and as the burial-transit	fedical Examine	Sequentially list conditions, if any, leading to immediate the second se	c	a consequence of								
.O. Box	death cer e attendin d for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)				23d. Date of deli		ear
rds, P	w requires that the been signed by the should be detache	þ	Part II. Other significant conditions of	contributing to death bu	it not resulting in t	the und	derlying cause give	en in Part I.	23e. Did t		use contribute to	the cause of de	
Division or Vital Records,	The law ate has b page 2 sl	Completed							24a. Was auto perfo 1∐ Yes		prior to o death?	opsy findings a ompletion of ca	vailable use of
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			la.	26. Place of Deat					
ō	Physer this eral dir	٦.	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatie				4 Li Nursing Ho	me 5 Resi 28d. Describe		6 ☐Other (Spec	ify)	
ion	Attending r death. ector; After oy the fune	atior	1' Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day		jury	28c. Injury Work M 1 🗆	k? Yes 2 □ No		11011 1119	ary occurred		
Divis	tal or Atters as after des	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of inju building, etc		m, stree	et, factory, office		28f. Location ( City or To	Street a wn, Sta	and Number or Ru te)	ral Route Numb	per,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (	29a. Certifier (Check only one)  1 Certifying Pr 2 Medical Exam	ysiclan: To the best on niner: On the basis of and manner sta	examination and/	death /or inve	occurred at the tin estigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause( date a	s) and manner as nd place, and due	stated. to the cause(s)	
	To T To 1	Σ	29b. Signature and title of certifier	W			29c. License				ate signed (Month		
•				MD	11 (1)		103	4849		Ju	ne 11	2007	
			30. Name and address of person who William Tan	completed cause of de	eath (Item 23a) (T	ype, P	int) R	4849 Locd &	Heis	our	MD 2	1784	
Ţ	Sta Registr		31. Date filed (Month, Day, Year)	32. Regist	r's Signature	*	South						

			1- For State of Maryland / Department of Health and Certificate of Death	Re	g. No. UU /	20433
	Dhuaiai		1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	n Day Year	3. Time of Death
	Physicia /Medic		John Walter Smith	June	7, 2007	8:30 p M
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Dea	ath	4c. County of Deat	th
			12 Pleasant View Church Road Port Deposit		1	ecil
Н	Funeral		Months Days Hours Mir	(Month Day	Year) 9. Bin 1932 Mai	thplace (State or Foreign cuntry) cyland
	Director		217-24-5364	100. 17,	1302 110.	yrana
	land ow		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Many -f sh fied	ţō	Maryland Cecil Port Deposit			1 ☐ Yes 2 😿 No
	r 28e	Directo	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Co	ountry?
	th wit		12 Pleasant View Church Road 21904		U.S.A	
	dea ems	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No- arto Rican, etc.)	14. Race - Ame Black, Whit	
9	or it	y F.	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No		Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. than "patural", or Itams 23e or 28e-f ahow the Madical Expirities roual be notified at	d by		1.	16b. Kind of Business	
7	n 72 nation	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of w			coving Ground
72	ther the	mo	Elementary/Secondary (0·12) College (1·4or5+) Seven Years Chemical Technician	E	dgewood, N	Maryland
0	Hyg Hyg other	BeC	17. Father's Name (First, Middle, Last)  18. Mother's Name	ame (First, Middle, N	faiden Sumame)	
<u>a</u>	id be lental kad ic ev	To B	unknown	Florence :	Mae Smith	
Maryland	shou and N	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Relationship)	Rural Route Number,	City or Town, State,	Zip Code)
Σ	er fre		Mary Ann Smith (wife) 12 Pleasant View Chur			
ore	of He fiten		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Removal from State	Date 2	20c. Location - City or	Town, State
<u>Ĕ</u>	Pag ment ant: I		4 Donation 5 Other (Specify) R.A. Ferris & Co., Inc. 06/	12/07	West Chester	, Pennsylvania
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene important: if Item 27 is marked other than "natural", or Itams 23a or 28e-f ahow important: if Item 27 is marked other than "natural", or Itams 23a or 28e-f ahow important in Item 1 in Medical Experiment near the multified at once.		21. Signature of Funeral Service License Lee A. Patterson & Perryville, Maryla	Son Fune and 21903-	ral Home, 0766	P.A.
E			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardi shock, or heart failure. List only one cause on each line.	ac or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition			Chisti and Dodan
	/Medical Examiner		Due to (or as a consequence of):			
		_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
	pet nsit	Examiner	Cause (Disease or injury			
	al-tra	xar	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
760,	te be executed ysicien and e burial-transit	cail	d			
9	g phy as th					
Box	death certifica e ettending ph d for use as th	Z .	IF FEMALE:  23b. Was decedent pregnant  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of de	
		by Physician/Med	1 Tyes 2 No 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
P.O.	at the	بخ	9 Li Unknown	on Bitti		
	The law requires that the ste hes been signed by the bage 2 should be detache		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		eaccoluse contribute t es 2 □ No 3 □ P	4
ord	w require been signature	Completed		- 1014		
ec	law lesb e2st	nple		24a. Was ar autops perform	n 24b. Were a prior to death?	utopsy findings available completion of cause of
<u>=</u>		ပ်			No 1 Yes	2 No
Vit.	Physician: Th this certificete ral director, pag	Be	examiner?	eath (Check only on		
of Vital Records,	Phys this ral dir	. To	1 inpatient 2 ENOutpatient 3 DOA 4 Nursing		nce 6 Other (Spenior occurred)	ecify)
0	ding Phy h. After thi funeral	tlon	27. Manner of Death  28a. Date of Injury  (Month, Day Year)  28b. Time of Injury 28b. Time of Injury 28c. Injury at Work?  1		. ,	
Division	l or Attanding efter death. Director; After I in by the fune	Certification:	3   Suicide 6   Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St. City or Town	reet and Number or R n, State)	lural Route Number,
	ospital or hours efte uneral Dir ly filled in		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla	and due to the es	auco(c) and manner a	e stated
	To the Hospital or Attant within 24 hours efter deatl To the Funeral Director; completely filled in by the	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death oc and manner stated.  29b. Signature and title of certifier  29c. License number	curred at the time, da	ate and place, and du	e to the cause(s)
)	T wil		Hamso A Grando MO 14280C		6/8/07	7
8	+ IVA		30. Name and address of person who completed cause of death (Item 23a) Type, Print)  HOURS A. HOURD 3/4 South UMON AVE	Ha6,	114,210	78
	Sta Regist		31. Date filed (Month, Day, Year)  JUN 1 1 2007  Acres Signature	/	/	

			1 - For State Registrar	State of	Maryla	nd / Depa <i>Cei</i>	artment rtificate	t of H	ealth a Death	nd M	ental Hyg	giene ( Reg. No.	1.17	20	:39
i	Physici	an	Decedent's Name (First, Middle, Last James B. Stakem	st)							2. Date of Dea Month June 8,	ith Day	Year	3. Time 6:25	of Death
	/Medio Examir		4a. Facility Name (If not institution, give		ber)		,.	Town, or	Location of	Death	oune o,		unty of Deat	h	рм
	Funeral Director		Social Security Number		7. Age (In yrs	. last birthday) Yrs.	If Under Months	^	If Under 2 Hours	4 Hrs. Min.	8. Date of Birth (Month, Day Jan. 6,	1919	9. Birt	hplace (State	or Foreign
	Maryland	tor	Usual Residence of Decedent           10a. State         10b. County           Maryland         Mor	itgomery	10c. C	ity, Town or Lo								10d. Inside 1 □ Ye	City Limits s 2 🛣 No
	3a or 28	Funeral Director	10e. Street and Number 10117 Capitol View	Avenue			10f. Zip		910			10g. Citizen	of What Co USA	untry?	
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heath and Mental Hygiene. Depertment of Heath and Mental Hygiene important: if item 27 is marked other than "naturel", or itame 23e or 28e-f ehow appring yor other traumatic event, ira Medical Eventrial mital be notified at once.	þ	11. Marital Status  1 Never Married 2 Married  3 Midowed 4 Divorced	12. Was Deced Armed Ford 1 1 Yes If Yes, Give Year or Da	ces? 2 ∐ No		Was Deced i Yes, spec	ify Cubar	spanic Orig n, Mexican, Specify:	in? (Spe Puerto F	cify Yes or No- Rican, etc.)		Race - Ame Black, White Black, White		
21215-0036	within 72 h iene. than "natu ina Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		4or 5+)	life. L	kind of wor DO NOT us	k done di	uring most	of workir	ng		f Business/	Industry	
Maryland 2	uld be filed Mental Hyg irked other	To Be C	17. Father's Name (First, Middle, Last)  James Bernard Staken	ı		Mechanio	2				(First, Middle, Sharpe		mobile		
	and 2 sho saith and i n 27 is ma		19a. Informant's Name/Relationship (Tharles B. Staken/Sor				_				Route Number			(ip Code)	
altimore,	Pages 1: ment of He ant: If Iten ury or oth		20a. Method of Disposition  1 3 Burial 2 Cremation 3 4 Donation 5 Other (Specify		tate	Place of Dispo cemetery, crem te of Hea	natory or ot	her place		tune 2007		20c. Locatio		Town, State	nđ
<b>Balt</b>	permit. Depertimport any inj		21. Signature of Juneral Service Licen	Sto	le	50	00 Univ	ersit	y Blvd	l, W.,	ral Home Silver	Inc. Spring,		•	
8760,	Physician and // Medical physician and // Medical Examiner   The prival - Italian	dical Examiner	23a. Part1. Enter the disease, or composition shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a. Due to (o	used the deach line.  On A M  r as a conservation as a conservatio	quence of):	Phy	e of dying	, such as c		r respiratory ari	est,		Approxim Interval Bi Onset and	etween
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as it	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Fet nt at time of	al death 3	Ectopic pre					23d.	Date of deli Month	very Day	Year
	w requires that been signed b should be deta		Part II. Other significant conditions or	ontributing to dea	ath but not re	sulting in the ur	nderlying ca	iuse givei	n in Part I.		23e. Did to			the cause of	death? ]Unknown
al Reco	n: The law re icate has be r, page 2 sho	Completed									24a. Was a autops perform	sy	b. Were au prior to d death? 1 \( \text{Yes}	topsy finding ompletion of 20 No	s available cause of
Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ion: To Be	27. Manner of Death  1 XNatural 5 ☐ Pending	28a. Date of		ER/Outpatien 28b. Time of Injury	28	A Other	4 □ Nurs	sing Hom	(Check only or ne 5 Reside 8d. Describe he	ence 6 🗆		ufy)	
Divisio	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e Place c	of Injury - At h g, etc. (Speci	nome, tarm, stre	M eet, factory,		es 2 N	-	8f. Location (Si City or Town		ımber or Ru	ral Route Nu	mber,
	ne Hospital or A n 24 hours after ne Funeral Dire bletely filled in b	Medical C	29a. Certifier 1 Certifying Physical Control (Check only one) 2 Medical Example 1	ysician: To the bas and manne	is of examin	owledge, death ation and/or inv	occurred a restigation,	it the time	a, date and nion, death	place, a	nd due to the c	ause(s) and late and plac	manner as ce, and due	stated. to the cause	(s)
) ,	204)	Ž	29b. Signature and title of certifier	Tomst	10	May, 4	29c.	License	number 5/9	16	2	June	ned (Month	Day, Year)	7
,	Ju . '		30 Name and address of person who of	completed cause	of death (Ite	m 23a) (Type, I	Print)	ike.	, G-,	100,	Rock	ville,	mi	20	852
British a	Sta Registr		31. Date filed (Month, Day, Year)	7 A	gistrar's Sign	ature	di)			7					

			State of Maryland / Department of Health and M  State of Maryland / Department of Health and M  Certificate of Death	,	giene Reg. No. 2 11 11 1	201.1.0
			Decedent's Name (First, Middle, Last)	2. Date of Dea	ith	3. Time of Death
	Physici /Medic		Carle N. Satterwhite, Jr.	June 8	Day Year 3, 2007	5:48 p M
	Examin	_	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Dea	
	30. 31.		Holy Cross Hospital Silver Spring		Montgome	
المراثد	Funeral Director		5. Social Security Number 220-58-8110  6. Sex 12 M 2 F 7. Age (In yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day June 22	r, Year) C	thplace (State or Foreign ountry) Iaryland
	land bw it		Usual Residence of Decedent  10a. State 10b. County 10c. Cify, Town or Location			10d. Inside City Limits
	Mary I-f sh fied a	to	Maryland Montgomery Silver Spring			1 ☐ Yes 2 🔀 No
	h the r 28a r noti	irec	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	ountry?
	th wit	al	12922 Georgia Avenue 20906		USA	
036	Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show up or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 ★★Never Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ★ No If Yes, specify Cuban, Mexican, Puerforces?  1 □ Yes 2 ★ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi Specify: Wh	te, etc.
21215-0036	thin 72 ho e. an "natur Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king	16b. Kind of Business	·
2	ed wii ygien ygien <b>t, the</b>	Con	12 Groundskeeper		Golf C	Course
Maryland	uld be fil Mental H rrked ott rtic even	To Be		ne (First, Middle, .e E. Har	Maiden Surname) Cris	
Mary	nd 2 sho lith and I 27 is ma r trauma		19a. Informant's Name/Relationship (Type. Print)  Marie E. Satterwhite/Mother  19b. Mailing Address (Street and Number or Ru  12922 Georgia Avenue,		•	•
Baltimore,	Pages 1 and 2 tent of Health a nt: If item 27 is ry or other trau		Fort Lincoln Cemetery	Date 13,	20c. Location - City or Brentwood,	
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Juneral Service Licensee  22. Name and Address of Facility  Francis J. Collins 500 University Blv	Funeral	Home Inc.	-
25	7-10		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			Approximate Interval Between
46	Physician		Immediate Cause (Final disease or condition Myocardial Infarction			Onset and Death
4	/Medical		resulting in death)  Due to (or as a consequence of):			
	Examiner		Sequentially list conditions b. Arteriosclerotic Cardiovascular Di	sease		
	pe sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  Obesity			
	and and II-tran	Examiner	Cause (Disease of Injury that initiated events resulting in death) Last  C. Obesity  Due to (or as a consequence of):			
68760,	eath certificate be executed attending physician and for use as the bunal-transit	edical E	d			
Box 68	certifica nding ph use as t		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy		23d. Date of de	liverv
P.O. Bo	the death certify the attending iched for use a	Physician/M	in the past 12 months?  1		Month	Day Year
	quires that the de n signed by the a uld be detached t	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	_	bacco use contribute t es 2  No 3  P	o the cause of death?
or Vital Records,	The law requires that the death certi ate has been signed by the attending page 2 should be detached for use a	Completed		24a. Was a autop perfor	sy prior to	utopsy findings available completion of cause of
ıta	Physician: Th r this certificate ral director, pa	Be	examiner?	th (Check only or	ne)	
>	hysicathis call dire	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing H		ence 6 ☐Other (Spe	ecify)
Ž	ding F	ii o	27. Manner of Death  1 ☐ Natural 5 ☐ Pending (Month, Day Year)  1 ☐ Natural 5 ☐ Pending investigation investigation  M M M 1 ☐ Yes 2 ☐ No	28d. Describe h	ow injury occurred	
Division	or Attencater death Director:	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 4 ☐ Homicide investigation  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	treet and Number or Fi n, State)	tural Route Number,
_	ospital hours uneral ly filled	edical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and manner stated.	e, and due to the curred at the time, o	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
)	To the H within 24 To the Fi	Me	29b. Signature and title of certifier  Mashul, mp 29c. License number D65509	2	29d. Date signed (Mon	th, Day, Year)
_	*		30. Name and ad for person who completed cause of death (Item 23a) (Type/Print) 500 Fore 15t and HEATHEN MARSHALL, Holy Cross Hospital	en Rd.	Tver Sprin	ng MD, 2091
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature			)

		Plea	se Type or Pri									•		
		1 - State Registrar			Cei	rtificate	of E	Death			Reg. No	.200	7	20441
Dhysiai		1. Decedent's Name (First, Middle	e, Last)							Date of De     Month	eath Da	ay Year		3. Time of Death
Physicia /Medio	_	Winifred Lee	Shoemaker							June		007		5:00 A M
Examin	er	4a. Facility Name (If not institution	n, give street and number)			4b. City, T	own, or	Location	of Death			c. County of De		
	7 0	Solomons Nursi: 5. Social Security Number		ne (In vrs b	ast birthday)	So1	Omor	1S If Under	24 Hrs.	8. Date of Bi		Calvert		e (State or Foreign
Funeral Director		578-05-7645	1 M 2 M F	89	Yrs.		Days	Hours	Min.	(Month, Da	ay, Year	1918 Ma	Country)	
		Usual Residence of Decedent								ZIPILL		1719 110		
trylan show	_	10a. State 10b. County		10c. City	, Town or Lo	ocation							10d.	Inside City Limits 1 ☐ Yes 2 ☑ No
ne Ma 8a-f s atifie	Director		vert	S	<u>olomor</u>			4			40 0		2	
with the		10e. Street and Number				10f. Zip (		_			10g. C	itizen of What (	Jountry:	
eath is 23amust	Funeral	13325 Dowell Ro	12. Was Decedent	Ever in U.S	S. 13.		.0688 ent of His		igin? (Sp	ecify Yes or No	0-	USA 14. Race - An	nerican I	Indian,
fter d r item liner	Fu	1 ☐ Never Married 2 ☐ Mar	Armed Forces?	?						ecify Yes or No Rican, etc.)		Black, Wh	nite, etc.	
urs a al", o	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1□Yes 2	⊠ No	Specify:				Specify:	WI	hite
72 ho natur ilical	eted	15. Deceden	t's Education st grade completed)		(Give	dent's Usual	k done d	urina mos	t of work	ing	16b. l	Kind of Busines	s/Indust	try
/ithin ne. han " e Mec	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		DO NOT use								
filed within 72 hours after death with the Maryland Hygiene. Hygiene, then "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at		12 17. Father's Name (First, Middle,	( ast)	1	Print	ting B			er's Name	e (First, Middle		vernmen	t	
d be f antal l ced of	o Be	Trigg Huston	_							ritting				
shoul nd Me mark	2	19a. Informant's Name/Relations			19b. Mailii	ng Address						or Town, State	, Zip Co	ode)
alth al 27 Is		Donald Shiffle	t- Son		104 I	Devon	Cour	t Si	1ver	Spring	g, M	D 20910		
ss 1 a		20a. Method of Disposition	0 FIR	20b. Pl	ace of Dispo					Date		Location - City of		, State
Page nent ant: If ury or		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 Li Hemovai from State Specify)		ematoı			1	6/8	/07	De	lmar De	1awa	are
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. It is not them 21 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Licensee B C	la	2:	2. Name and	Addres	s of Facil	<sup>ty</sup> Bo	unds Fu	uner	al Home		
20529		Apl Sin	ver min									MD 218		
		23a. Part . Enter the disease, o shock, or heart failure. List	only one cause on each l	ine.						or respiratory a	arrest,		Init	pproximate terval Between nset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			N501	U.S.	Dis	SEA	SE.					
Examiner			Due to (or as	a consequ	ierice or).									
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequ	ience of):									
executed n and ial-transii	Examiner	Cause (Disease or injury that initiated events	С											
e exe		resulting in death) Last	Due to (or as	a consequ	ence of):									
eath certificate be executed attending physician and for use as the burial-transit	Physician/Medical		d										-	-
certifi ding l	/Me	IF FEMALE:	23c. If yes, outcome	e of pregna	ncy							23d. Date of c	lelivery	
atten I for u	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐Live birth 4 ☐ Pregnant a	2 ☐ Fetal	death 3	□Ectopic pre □ Other (spe						Month	Da	ay Year
t the c by the ached	hysi	9 Unknown	9□Unknown											
The law requires that the death certificate be the has been signed by the attending physicionage 2 should be detached for use as the bu	by P	Part II. Other significant conditi	ons contributing to death t	out not resu	ılting in the u	inderlying ca	ause give	n in Part	1.					cause of death?
equire en sig										1	] Yes	2 No 3	Probabl	ly 4 🗷 Unknown
e law r has be	Completed									24a. Was	opsy	prior t	o compl	y findings available letion of cause of
	Con									per 1□ Yes	formed? 2 N	death 1 ☐ Y	? es 2[	□No
ician: Th certificate ector, pag	Be	25. Was case referred to medica examiner?	Llospital:				Othe	/		h (Check only				<del> </del>
Attending Physician: r death. ector: After this certifica by the funeral director, p	: To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpati		ER/Outpatie		A	4 L N	ursing Ho	ome 5 Res 28d. Describe		6 □Other (Spurv occurred	pecify)	
ding th. After	tion	Natural 5 ☐ Pending 2 ☐ Accident investi	ng (Month, Da		Injury	м	Bc. Injury Work 1 □ \	k? Yes 2 □	No		,	.,		
Atter r deal ector by the	ifica	3 Suicide 6 Could 4 Homicide detern	ained   28e. Place of III	jury - At ho tc. (Specify		reet, factory	, office			28f. Location City or To	(Street a	and Number or	Rural R	Route Number,
tal or saffe	Certification:	4 El Torniciae	building, e	ito. (opeciny						Ony or 10	own, ola			
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur	edical		ng Physician: To the best Examiner: On the basis of and manner s	of examinat										
Fo the vithin or the comple	Mec	29b. Signature and title of certific				290	. License	number			29d. D	ate signed (Mo	nth, Daj	y, Year)
F > F 0		> Peter	m			1	040	037	10		4	0/7/0	7	
		30. Name and address of persor	who completed cause of	death (Item	23a) (Type,	, Print)			_			/ '		
		Peter Wisniews						e. 3	10,	Prince	Fre	derick,	MD	20678
Sta Registi		31. Date filed (Month, Day, Year,	1 2007 32. égist	rars Signa	ture	month								

DHMH 17 Rev 1/2001

		1 - For State Registrar	St	ate of N	/larylan		artment of H		ınd Mer		giene Reg. No.	2111	7	201	:42
Physici		1. Decedent's Name (First, Martha	Middle, Last) Gray				Thomas			Date of Dea Month	Day		ır	Time of [	M
/Medic		4a. Facility Name (If not inst	itution, give stree	t and numbe	r)		4b. City, Town, o	r Location of		une 6		County of D		:55	P "
k - #		6011 Brooksi	de Drive				Chevy C	hase			Мо	ntgome	rv		
Funeral		5. Social Securify Number	6. Sex 1 ☐ M			last birthday)	If Under 1 Year Months Days	If Under 2	Min.	Date of Birt (Month, Day	h /, <i>Year</i> )	9. 6	Birthplace Country)	(State or	Foreign
Director	0	222-05-9945 Usual Residence of Decede			94	Yrs.			N	larch	24,1	1913 E	1kmon	it, A	.L
/land ow		10a. State 10b. C			10c. Cit	y, Town or Lo	cation						10d. Ir	nside City	/ Limits
Many a-f sh ified	j	Maryland Mor	tgomery		Che	evy Ch	ase						1	Yes	2□No
or 28,	Funeral Director	10e. Street and Number				<u>_</u>	10f. Zip Code				10g. Citi	zen of What	Country?		
ath wi	ral	6011 Brooks					20815					S.A.			
er de items ner m	ine	11. Marital Status 1 □ Never Married 2□	A	Vas Deceder Irmed Forces ☐ Yes 24	3?	.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origi an, Mexican,	in? (Specify , Puerto Ric	/ Yes or No- an, etc.)		14. Race - Ai Black, W		dian,	
ırs afl al'', or 'xami	by F	3K2XWidowed 4 □ Div	If	Yes, Give ear or Dates			1 ☐ Yes 2 ☐ No	Specify:				Specify:	White		
72 hou natura ical E	Completed	15. Dec	edent's Education highest grade con	n eplatad)			dent's Usual Occup		of working		16b. Ki	nd of Busine			
ithin 7	nple	Elementary/Secondary (0		college (1-40	r 5+)	life.	DO NOT use retire	d)	or working						
led w tygier her th	ပ်	17 Fatharia Nama (First Ad		4		Home	naker	10 Makes	d- No (C	tank Baladalla		Home			
d be findal Hed of	Be	17. Father's Name (First, M. Fr'ed	ray					Kathe	,	irst, Middle,					
should nd Me mark matic	2	19a. Informant's Name/Rela		Print)		19b. Mailii	ng Address (Street					orth	Zin Cod	 a)	
nd 2 suith ar 27 is 27 is r trau			ves – da		r		) Galashi				-				
is 1 a	-	20a. Method of Disposition			20b. F		sition (Name of matory or other pla		Date			cation - City			
Page nent c		1 X Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth		val from Stat	e		Cemetery	1	une 13	3. 07	Rock	ville,	. Md		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.		21. Signature of Funeral Se	rvice Ligense				2. Name and Addre	ss of Facility	/ Jose	ph Gav	wler	's Son	s Ind		
205 20		W. Mic sig	1 16. Ven	y			30 Wiscon					ton, D			
Physician /Medical		23a. Part1. Enter the dis, a shock, or heart fail re Immediate Cause (Final disease or condition resulting in death)	se, or complication. List only one ca	Recur	rent ] as a conseq	Pneumo: uence of):		ng, such as c	cardiac or re	espiratory ar	rest,		Inte	roximate rval Betw et and De Yea	een eath ITS
Examiner	ner	Sequentially list conditions,	b. —	Wasti Dum to (ore		ndrome							3-4	Yea	rs
icate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c	Anore									3-4	Yea	rs
oe execian a	ĕ	resulting in death) Last		Chron		,	ted State	ı					3-4	Yea	ırs
physicate by the b	edical		d										+ - '		
the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending physician and nitlet and prector and the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Me	IF FEMALE: 23b. Was decedent pregna in the past 12 months' 1 □ Yes 2 ☒ No 9 □ Unknown	," 1	yes, outcom □Live birth □Pregnant □Unknown	2 ☐ Feta	Ideath 3	Ectopic pregnanc	<i>y</i>			2	23d. Date of o Month	delivery Day	Ye	ear
s that ned by deta	by Ph	Part II. Other significant co	nditions contribu	ting to death	but not resu	ulting in the u	nderlying cause giv	en in Part I.		23e. Did to	bacco u	se contribute	to the ca	use of de	ath?
w require been sig should be									_	1 🗆 Y	'es 2	© No 3□	Probably	4 □Ur	ıknown
law re	Completed								Ì	24a. Was a		24b. Were			
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nysician: The faw nis certificate has t director, page 2 s	Be (	25. Was case referred to m examiner?	1				Laurence Communication (Communication Communication Commun		of Death (C	heck only o	ne)	7.5	=		
Physi this c al dire	ဥ	1 Yes 2 No	Hospi	i ∐ inpa		ER/Outpatier		4 L Nurs				6 □Other (S	oecify)		
ding Ph	ioi		ending vestigation	Ba. Date of In (Month, D	Day Year)	28b. Time o Injury	Wor	yat k? Yes 2 ∐ N		. Describe h	ow injur	y occurred			
al or Attending Pr s after death. al Director; After th ed in by the funeral	Certification:	3 Suicide 6 □ C	ould not be	Be. Place of in building,	njury - At ho etc. <i>(Sp</i> ec <i>if</i>	ome, farm, str	eet, factory, office	163 Z	-	Location (S City or Tow	treet and n, State	d Number or )	Rural Rou	ite Numb	er,
To the Hospital of within 24 hours aft To the Funeral D completely filled in	Medical (	29a, Certifier 1 ☑ Cer (Check only one) 1 ☑ Cer	tifying Physician	n: To the bes On the basis and manner	of my kno of examina tated.	wiedge, deat lion and/ør in	occurred at the ti vestigation, in my	me, date and opinion, deatl	d place, and th occurred	due to the dat the time,	cause(s) date and	and manner place, and c	as stated.	cause(s)	
To the within To the comp	Me	29b. Signature and title of c	ertifie	11	//	//	290. Licens		_	-	29d. Dat	e signed (Mo	nth, Day,	Year)	
24		1/x	A				MD	31167	7		6	(7(0	+		
- 1		30. Name and address of pe					Print)			DC 20	017				
		Peter J. Ouel 31. Date filed (Month, Day,			New I		Ave. NW V	ashing	gton,	של אל	ΩΙΌ		· · · · · · · · · · · · · · · · · · ·		
Sta Registr			1 2007	a logic	a. o olgila	le de	ach D								

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2007 РМ 1442 Marjorie Marie Valentin June 16 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cecil E1kton Union Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 💢 F Yrs. 17, Virginia May 70 Director 215-32-7931 Usual Residence of Decedent 10d. Inside City Limits 10c City Town or Location rthan "natural", or items 23a or 28a-f show the Medical Exeminer must be notified at 1 ∑Yes 2 ☐ No Director Maryland E1kton Cecil 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21921 121 Mallard Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 2 White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mobile Home permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Electrician 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Myrtle Blankenship Orville Hawkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 121 Mallard Court, Elkton, Maryland 21921 Esteban B. Valentin/Husband June 21, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Gilpin Manor Memorial Park 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 Elkton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) P.A. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, Maryland 21921 21. Signature of Funeral Service Licensee 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Neuro /Medical (or as a consequence of): Examiner consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as Examine The taw requires that the death certificate be executed burial-transit and to (or as a consequence of); ate has been signed by the attending physician page 2 should be detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical MONING IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 menths?
1 Yes 2 No Day Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 3 ▼ Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 2XN0 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tyes Certification: To 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Mayiner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 5000ED 756 mpleted cause of death (Item 23a) (Type, Print) MainSt Elt C 31. Date filed (Month, Pay, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Enmance 07-04614 UNK UNK	1 (	کرار نویمیخ Please Type or Print in Black Indelible Ink State of Maryland / Department of H	. Ensure All Copi	es Are Leg	ible.	
OINK OINK		State of Maryland / Department of H 1- For State Registrar Certificate of D			g. No. 200	7 201:16
Physicia Medical Exami	an/	Decedent's Name (First, Middle,Last)		2. Date of Death Month June 17, 20		3. Time of Death 0002 hrs
Medical Exami	iiei	Emmanuer william w	<u>i L Liams</u> City, Town, or Location of Dea		4c. County of Death	
		Route # 210 @ Swann Creek Road	Fort Washingon		Prince George	
Funeral Director			f Under 1 Year If Under 24H Months Days Hours Mi	_	h(MM/DD/YYYY) 9. Bir Foreig Co	
	46.4	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location				10d. Inside City Limits
/land -f shov	ector		n Hill	140	g. Citizen of What Cou	1 Yes 2 No
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene of Health and Mental Hygiene unf. If item 27 is marked other than "natural", or items 23a or 28a-f show; or other traumatic event, the Medical Examiner must be notified at once.	اة	5428 Livingston Terrace #201	0f. Zip Code 20745		U.S.A.	
or itens 2	Funeral	1 X Never Married 2 Married Armed Forces? If Yes, 1 Yes 2 X No	ecedent of Hispanic Origin? ( specify Cuban, Mexican, Puer		White, etc.	ican Indian, Black,
2 hours after "natural",   Examíner	by	or Dates:	es 2 No specify: Usual Occupation (Give kind o	work done	SpecifyBlac	
5-0036 led within 72 hours a Hygiene other than "natura the Medical Examin	Completed		of working life. DO NOT use re			-1 -1
e, MD 21215-0036  I and 2 should be filed within 72  Health and Meintal Hygiene item 27 is marked other than r fraumatte event, the Medical	dmo	12 Move			Private	Co.
215-( be filed vantal Hygerked other other)	Be Co	17. Father's Name (First, Middle, Last)  Emmanuel Boone		ne (First, Middle, M		
y, MD 21218 and 2 should be fill lealth and Mental F tem 27 is marked traumatic event, it	To B	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing A	ddress (Street and Number o	Rural Route Num	L1 ams ber, City or Town, State	e, Zip Code)
e, MD I and 2 sho Health and item 27 is		Patricia Boone/Mother 5428Li	vingston Te	race #2	<u>201, Oxon</u>	<u>, Marylan</u>
or Heal		20a. Method of Disposition  1	place)	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages I ar Department of Hee Important; If ite		4 Donation 5 Other Specify: Rosehill			Linden, Ne	
Baltimore permit. Pages 1 s Department of H. Important; If it injury or other t			ne and Address of Facility M 19 Harford R	arzullo	Funeral	Chapel, P.
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	mode of dying, such as cardiac	or respiratory arre	est, shock, or heart	pproximate Interval Between Onset and
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries				Death
2Adilliloi		or condition resulting in death)  Due to (or as a consequence of):				
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	amine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death.) Last Due to (or as a consequence of):				1
tecuted and transit	<u>~</u>	events resulting in death) Last Due to (or as a consequence or).	·			
) be exection a	dica					
Box 68760, e death certificate be execut the attending physician and ed for use as the burial - tra	sician/Medical	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal	death 3 Ectopic preg	nancy	23d. Date of deliver	y Day Year
lox 68 leath certi e attendin for use as	iciar	past 12 months?  4 Pregnant at time of death 5 Other	· (Specify)	nancy		20,
. <b>Bo</b> he deat the at hed for	Phys	1 Yes 2 No 9 Unknown g Unknown	adding across shown in Dort I	23e Did to	bacco use contribute to	the cause of death?
P.O. es that the gened by edetach	by	Part II. Other significant conditions contributing to death but not resulting in the und	enying cause given in Fait i.		2 <b>✓</b> No 3 Pro	
ds, equire	eted			24a. Was a		utopsy findings available
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and impletely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Completed			autop perfor 1 ✓ Yes	med? death?	completion of cause of es 2 No
II Re		25. Was case reterred to medical	26.Place of Death (Chec			00 2 70
Vita hysicia this ce	ro Be	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3			Residence 6 V Othe	er: Scene
Ing Pl	on: T	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month Day Year) 28b. Time of Injury (Month Day Year) 2345 hrs			now injury occurred struck by auto	
Sior Attend r death ector: by the	Certification:	Natural 5 Pending Investigation Investigation 28e. Place of Injury - At home, farm, street,	1 Yes 2 No	28f Location (S	Street and Number or R	ural Route Number City
Divi	ertifi	3 Suicide 6 Could not be determined (Specify) Major Road / Highway	ractory, office building, etc.	or Town, S	tate) ② Swann Creek Roa	
Hospi 24 hou Funer tely fil		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred	d at the time, date and place, a	nd due to the caus	e(s) and manner as sta	ted.
Divisior  To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation and manner stated.		d at the time, date		
	ž	29b/Stanature and title of certifier	29c.License number		29d. Date signed (Mo	onth, Day, Year)
		( (alocery)	O.C.M.E.		June 17, 2007	
3		30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 111 Penn S	treet, Baltimore, MD 2	1201		
	tate	31. Date filed (Month, Day, Year)   2. Registrar's Signature	•			
Regis	trar	JUNY D COUL VIEWED YOU HAVE				

			1 - For State Registrar	State of M	Maryland / De	partmer <i>ertificat</i>					giene Reg. No.	00	7	201,	35
	Physici	an	Decedent's Name (First, Middle, La.							2. Date of De Month	ath Day	Ye	ear	3. Time of D	eath
н	/Medi		NORMA JOSEPH		****						18,2			7:50P	М
н	Examir	ner	4a. Facility Name (If not institution, give			4b. City,	Town, or	r Location	of Death		4c.	County of C	Death		
			GENESIS LA P					PLA				CHARL			
	Funeral		5. Social Security Number 6. S	ex	nge (In yrs. last birthd 83 Yrs	Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da	th ly, Year)	g.	Birthpla Countr	ace (State or F ry)	-oreign
	Director		112-16-3479 1 Usual Residence of Decedent	Λ	03 "					11-8-	1924	N	I.Y.		
	dand ow		10a. State 10b. County		10c. City, Town o	r Location							100	d. Inside City	Limits
	Many Heat	ξ	MD. CHARL	ES		LA	PLA	TA						1 X Yes 2	. No
	with the Maryland a or 28a-f show	Director	10e. Street and Number			10f. Zip	Code				10g. Citiz	zen of Wha	t Countr	ry?	
	h witi	O E	#1 MAGNOLIA	DRIVE				2064	6		Ū	J.S.A			
	deal	ner	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S.	13. Was Dece	dent of H	ispanic Ori	igin? (Spe	ecify Yes or No Rican, etc.)	- 1	4. Race - A			
9	or It	by Funeral	1 Never Married 2 Married	1 ☐ Yes 2 X		1 ☐ Yes		Specify:		riicari, etc.,		Black, V Specify:			
8	n 72 hours after death with the Maryland "netural", or Items 23a or 28a-f show edical Examinatinus! be inclided at	d b	3 ¼Widowed 4 □ Divorced	Year or Dates								opcony.	WHI	TE	
7	"nat	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(0	ecedent's Usu live kind of wo e. DO NOT u	rk done o	during mos	t of work	ing	16b. Kir	nd of Busine	ess/Indu	ustry	
7	within ene. than "	Ĕ	Elementary/Secondary (0-12) 12th	College (1-4or	5+)	HOMEM					OLINI	TIOM			
d 2	Hyg ther int,		17. Father's Name (First, Middle, Last)			ALOUILIN	יביייביי		er's Name	(First, Middle,		HOM Sumame)	<u>r</u>		
au		To Be	JOHN CHIAMUI	LERA						COLET		,			
Maryland 21215-0036	d 2 should th and Men 7 Is marks traumatic	-	19a. Informant's Name/Relationship (	Type, Print)	19b. M	ailing Address	(Street a			A Route Number		Town, Star	te, Zip C	Code)	
	2 4 2 8		LESLIE NICHOLS	SON-DAUG	HTER 766	5 CAR	OL I	RD. 1	PORT	TOBAC	700-	MD 2	067	7	
Je,	Ø ← E ∪													n, State	
E	Page nent c int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specify	Removal from State  /)  M	ETROPOLI	TAN C	REMA	YTOR!	Y 6-	20-07	ALE	X V.	Α.		
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licer	see MOO4									•		
Ω	\$2 <b>E E</b> 8		Muchant	0.4		LA PL	ATA	MD.	КАL 206	SERVIO	CE,P	.A.			
Н			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	olications that cauca	d the death. Do not line.						rrest,		1	Approximate Interval Betwe	en
	Physician		Immediate Cause (Final disease or condition		( agalic	hul	non	aly	D	lle A				Onset and De	ath
	/Medical Examiner		resulting in death)		s a consequence of):		_		7						
	Lxammer	_	Sequentially list conditions,	Breast	MUCA	tic	0	nur							
	ed sit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence of):										
2	and and I-tran	хап	that initiated events resulting in death) Last	c. Due to (or a	s a consequence of):										
8760	death certificate be executed e attending physician and ad for use as the burial-transit		l												
687	ficate physics the	Physician/Medical	•	d											
Вох	death certifics attending ph of for use as t	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		_					2	3d. Date of	delivery	,	
m.	death e atte d for	icia	in the past 12 months? 1 □ Yes 2 No	4☐Pregnant a		3 □Ectopic pr 5 □ Other (sp						Month		ay Yea	ar
P.O.	t the by the	hys	9 Unknown	9∐ Unknown											
	The law requires that the de ate has been signed by the a page 2 should be detached f	ру Р	Part II. Other significant conditions of	ontributing to death	but not resulting in th	e underlying c	ause give	en in Part I.		23e. Did to	obacco us	e contribut	e to the	cause of dea	.th?
ğ	w require been si should b									1 🗆 \	res 2□	]No 3□	Probab	oly 4 Wunk	nown
900	has be	Completed								24a. Was autop		24b. Were	autops	sy findings ava	ailable
E E	The ate h page	POL								perfo	rmed? 2.23No	death	h?	□ No	30 01
/ita	Physician: r this certific ral director.	Be (	25. Was case referred to medical examiner?					26. Place	of Death	(Check only o					
<u>}</u>	hysi this c al dire	ဥ	1 Yes 2 No	Hospital: 1 ☐ Inpati			_	4 Nu		ne 5 Resid			Specify)		
Ĕ	ling F	lon:	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Inj (Month, D.	ury 28b. Tim ay Year) Injui		8c. Injury Work			28d. Describe h	now injury	occurred			
Sic	Attending r death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be		njury - At home, farm,	M		Yes 2 □ I	-	206 1 aanting /0		1 \$ 1	. 0	O	
ź.	after Direction by	Certification;	4 ☐ Homicide determined	building, e	itc. (Specify)	street, ractory	, onice		1	28f. Location (S City or Tox		ivumber or	r Hurai F	Houte Number	<i>,</i>
	spital		29a. Certifier 1X Certifying Ph	vsician: To the best	t of my knowledge, d	eath occurred	at the tim	e. date an	d place, a	and due to the	cause(s) a	and manner	r as stat	ed.	
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edicai	(Check only 2 Medical Examone)	iner: On the basis and manner s	of examination and/o	investigation	, in my op	oinion, dear	th occurre	ed at the time,	date and	place, and	due to th	he cause(s)	
	To th Withir To th comp	Me	29b. Signature and title of certifier			290	. License	number			29d. Date	signed (M	onth, Da	ay, Year)	
			· Www.ke	JUIND	)	1	100	616	5 2		6	119/0	2		
	~		30. Name and address of person who	completed cause of	death (Item 23a) (Tyl			- 1 -							
	2		RAVI SINDHWAN		50 PEMBE	ROOKE	SO.	WAL	DORE	'_MD	2060	2			
	Sta	1	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	1 1	**		_	7.10.	2000	4			
	Registr	ar	JUN 2 5 70	107 1	a. At I	melle									

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician WALDON, SR. LEONARD 5:30 A 2007 JUNE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S LANDOVER 2101 E. WILSON PLACE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye APRIL 26 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6 1935 Months Days Hours 1 M 2 ☐ F MARYLAND Yrs 72 Director 215-32-4503 Usuat Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f ehow Pages 1 and 2 should be filed within 72 hours after death with the Maryla nant of Heatth and Mental Hygiene.

ant: If Item 27 ie marked other than "natural", or Iteme 23a or 28a-1 ehov ury or other traumatic event, I'm Madical Examinational be natified at 1 XYes 2 No PRINCE GEORGE'S LANDOVER Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20785 2101 E. WILSON PLACE Completed by Funeral Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Specify: AFRICAN AMERICAN 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: -ERA 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th Coltege (1-4or 5+) PRIVATE PRIVATE CONTRACTOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NELLIE V. HAYCOCK GEORGE WALDON ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2101 E. WILSON PLACE LANDOVER, MARYLAND 20785 DREMA WALDON/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 DBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. CHELTENHAM, MARYLAND MD VETERANS CEMETERY 6/13/2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ase or condition sulting in death) PROSTATE CANCER Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner lew requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Į. Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ₩Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 2 No 1 Yes certificate 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA tuneral 28a. Date of Injury (Month, Day Year) 27. Magner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After A hours effer dea. 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 124 hours et 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) P. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie JUNE 7, 2007 Welleras, M.D. MD# 20459 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANTHONY G. ARCENAS, M.D., VAMC 50 IRVING STREET NW, WASHINGTON, DC 20422/688 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 1 2007 Registrar

burial-tran and

signed by the attending physician the detached for use as the buria

funeral

filled in by

29b. Signature and title of certifier

CASPER

31. Date filed (Month.

30. Name and address of person who/completed cause of death (Item 23a) (Type, Print)

LINE

To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Dora Viola Waters 00:50 A M June 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Homewood at Crumland Farms Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 □ M 2 🗓 F 216-80-9046 88 Director Nov 15 1918 Sandy Hook, MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Frederick 1 ☑ Yes 2 ☐ No Brunswick Director 10e. Street and Number 311 Walnut Street 10g. Citizen of What Country? 10f. Zip Code 21716 USA Funeral 12. Was Decedent Ever in U.S. Armed F*o*rces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 🖾 No Specify þ Specify: 3 Widowed 4 □ Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Housewife Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Alton Payne Edith Golden Myers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 637 General Early Drive, Harpers Ferry, WV 25425 Susan Alexander, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 P Burial 2 □ Cremation 3 □ Removal from State Brownsville Heights 6/13/07 4 □ Donation 5 □ Other (Specify) Brownsville, MD 22. Name and Address of Facility John T. Williams Funeral Home 21. Signature of Fuleral Service Acense Market Service Barbara A. Williams, Owner 100 Petersville Road, Brunswick, MD 21716 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) > Weeks **Physician** unon /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unkaown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 25. Was case referred to medical Be 26. Place of Death (Check only on examiner? Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 8 - No 2 ☐ ER/Outpatient 3□ DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time at 28d. Describe how injury occurred Injury at Work? Certification: 5 ☐ Pending investigation Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar strar's Signature

300 WEST NINTH ST. FREDERICK MD.

29c. License number

29d. Date sign (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:45 am June 2007 Wilson Betty /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 15712 Allnutt Lane **Burtonsville** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days (Month, Day, March 14, 1 □ M 2 🔀 F Yrs. Maryland Director 214-34-6908 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryls Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 X No Director Burtonsville Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20866 U.S.A. 15712 A11nutt Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify: **À** White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bus Operator Public School System 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Cecila Lavin Charles Perry Musgrove ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6462 Empty Song Road, Columbia, Maryland Thomas Wilson - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 6/8/2007 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician Breast Cancer** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-tran attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) 1 Yes 2 No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s performed? 2**K** No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Yes 2 🙀 No 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide f 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

10

Division or Vital Records, P.O. Box 68760

Saltimore, Maryland 21215-0036

State Registrar 31. Date filed (Month, Day, Year) 1 1 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

29b. Signature and title of certifier

Joseph Reilly,



10

29c. License number

D39190

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month 8:30 A<sup>M</sup> 2007 John Stewart Young, Jr. June 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Prince George's Hospital Cheverly 5. Social Security Number 6. Sex 1 XM 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Months Min. Hours Yrs. Director 578-38-1248 83 Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits r than "natural", or Itema 23a or 28a-f ehow the Medical Examinar must be notified at 1 X Yes 2 ☐ No Director Maryland | Prince George's Forestville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3100 Viceroy Avenue 20747 United States Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene. 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Master Carpenter Government other 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event potes. 18. Mother's Name (First, Middle, Maiden Surname) John Stewart Young, Sr. Cornealia Gertrude Liscomb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred E. Young/Spouse 3100 Viceroy Avenue, Forestville, MD 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 6/12/2007 Brentwood, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stewart Funeral Home 4001 Benning Rd., NE Wash., DC 20019 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (g a consequence of) Examine ted by the attending physicien and detached for use as the burial-transit The law requires that the death certificate be executed in Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes Division of Vital 2 To the Hospital or Attending Physician: "within 24 hours after deeth.

To the Funeral Director: After this certifica tor: After this certific the funeral director, 25. Was case referred examiner? 26. Place of Death (Check only one) 2 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Tes Inpatient 2 ER/Outpatient 3□ DOA Date of Injury (Month, Day Year) Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Thomicide cai 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifies 29c. License number 29d. Date signed (Monty, Day, Year) s of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Sign State Registrar

			1 - For State Registrer	State	of Marylan		rtment of			lental H	ygiene Reg. No	2007	201	,50
	Physicia /Medic		Decedent's Name (First, Middle,     VIOLET MAE Y							2. Date of D Month June		2007 Year	3. Time of 0 4 3 5	Death A M
	Examin		4a. Facility Name (If not institution, Harrison Seni				4b. City, Town, Snow H		n of Death			County of Dea	ith	
	Funeral Director		231-14-5365	i.Sex 1 □ M 2 💢 F	7. Age (In yrs. 86	last birthday) Yrs.	If Under 1 Year Months Days		er 24 Hrs. Min.	8. Date of E (Month, I 6 / 28 /	Sirth Pay, Year, 192(	9. Bit 0 NO	nthplace (State of ountry) rth Ca	rForeign rolin
	Maryland	lor	Usual Residence of Decedent  10a. State 10b. County  Worces	ter		y, Town or Lo ▼ Hill							10d. Inside Ci	
	3a or 28a-	Funeral Director	MD Worces  10e. Street and Number  430 W. Market		k		10f. Zip Code 21863				_	itizen of What C	ountry?	
-0030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The proportent: If item 27 is marked other than "natural", or items 23 a or 28s-1 show any injury or other traumatic event, the Medical Examinar must be notified at ODEs.	þ	11. Marital Status  1 Never Married 2 Marrie  3 Nidowed 4 Divorced	Armed F d 1 Tyes If Yes, G Year or I	<b>≱(∑</b> No ive	1	Vas Decedent of it Yes, specify Cul	o Specif		ecify Yes or f Rican, etc.)		14. Race - Am Black, Whi Specify: Wh	ite, etc.	
.CI717	d within 72 giene. ir than "na ine Medic	Completed	(Specify only highest Elementary/Secondary (0-12) 1 2	grade completed,	1-4or 5+)	(Give	kind of work done OO NOT use retir	e during me	ost of work	in <i>g</i>		ocery	zinoustry	
/land	uld be file Vental Hyg irked othe	To Be C	17. Father's Name (First, Middle, La Thomas Trainu							e (First, Midd e Eva		n Sumame)		
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altimore	Pages 1 ment of He ant: if iter lury or oth		20a. Method of Disposition 1  Burial 2  Cremation 3 4  Donation 5  Other (Spe		Curto	emetery, cren	sition (Name of natory or other pl. ce	ace) em .		/2007		comoke	City,	MD
מפ	permit. Depart import any inj once.		21. Signature of Funeral Service Li	Dan		Hb	. Name and Addi	reral I	bre, I			den Awe.,	Poconoke Maryland	
	Physician		Part1. Enter the disease, or c shock, or heart failure. List or Immediate Cause (Final disease or condition	omplications that nly one cause on	caused the deat each line.		ar the mode of dy	_			arrest,		Interval Bet Onset and I	ween
	/Medical Examiner	_	resulting in death)  Sequentially list conditions,	b	(or as a conseq	vedce of):								
,0070	ate be executed hysicien and the burial-transit	ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conseq									
O. DOX 0	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Attended to the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 No 9 □ Unknown	1 Live	utcome of pregna birth 2 Fete nant at time of d nown	death 3	Ectopic pregnant	су			-	23d. Date of de Month	-	Year .
colds, r	quires thet n signed b uld be deta	Ď	Part II. Other significant condition	s contributing to	death but not res	ulting in the ur	nderlying cause g	jiven in Par	rt I.		i tobacco ] Yes 2		to the cause of c	
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	Physiciar this certif al directo	To Be	25. Was case reterred to medical examiner?  1 ☐ Yes 2 ☑ No  27. Manner of Death	Hospital: 1 28a. Date		ER/Outpatien	t 3L DOA	ther: 4 🕠	Nursing Ho	me 5 Re 28d. Describ	sidence	6 Other (Sp.	ecify)	
101810	To the Hospital or Attending Physician: The law within 24 bours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 ompletely filled in by the funeral director, page 2.	Certification:	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	tion (Mor	nth, Day Year)	Injury	M 1 [	]Yes 2[	□No				Rural Route Num	ber.
2	spital or /		4   Norlicide	Physicien: To th	ling, etc. (Specif	y) 			and place.		own, Stat		is stated.	
	ithin 24 h	Medical	(Check only 2 Medical E.	ceminer: On the l	pasis of examina nner stated.	tion and/or inv	estigation, in my	opinion, do	eath occurr	red at the tim	e, date an	ate signed (Mor	e to the cause(s	s)
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~			30. Name and address of person w  160 4 - Mauk  31. Date liled (Month, Day, Year)	et St	Registrar's Signa	TAMA	ke.	Mi	) 2	2185	51	Sarad Bar	ar, MD	
I	Sta Registr			2007	Eleve	H B	barle				_			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death <sup>Day</sup> 2007 **Physician** 10:30P M 6, June Zisman Baitz Esther /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery 10201 Grosvenor Place Rockville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
DEC. 26, 1909 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 X F 97 Maryland Director 220-56-3291 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show at Yes 2 No notified Director Rockville Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number r than "natural", or items 23a or the Medical Examiner must be United States of America 20852 10201 Grosvenor Place death v Funeral 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black White etc 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Caucasian Specify: ģ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 4 Secretary 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Bertha Asrale Jacob Baitz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 12102 Whippoorwill Lane; Rockville MD 20852 Mildred Hamer - Sister Baltimore, Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 06/10/07 Falls Church, Virginia King David Mem. Pk. 21. Signature of Fineral Service Licensee 22. Name and Address of Facility Hines Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave. Silver Spring MD 20852 23a. Parti-Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. I year Immediate Cause (Final disease or condition resulting in death) Bladder Cancer **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? 1 Yes 2 No Month Day Year 5 ☐ Other (specify) Division or Vital Records, P.O. the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 【XNo 3 ☐ Probably 4 ☐ Unknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 s autopsy performed? 1 Yes 2 X No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier June 9, 2007 D09834 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3720 Farragut Ave. Rosenbaum M.D. Kensington, MD 20891 N. Barry

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN

11

2007

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registra Amend #12 Per FH g868 6/26/07 emificate of Death 2. Date of Death **Physician** Month Mary Louise Anzulis 200 /Medical 0 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore County Maples of Towson Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F Months Days Hours Min. 89 220-01-3033 Director Maryland July 04,1917 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Baltimore County Towson 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 104 Longdale Road 21093 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 12. Yes 2 2 4 0 If Yes, Give 17. 17. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify Specify: White H-W-II 3 AWidowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home unkn. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bernard Dunn Louise Wassmuth ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21286 906 Breezewick Circle Mrs. Pat Fuchsluger (Niece) Towson, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ott 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Mem. June 30,07 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each line. 23a. Part Enter the diseas ships, or heart slure. Imme sar Caus (in al diseas or condition **Physician** diseas or condition resulting in death) /Medical or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner cardio Vascular disease or Attending Physician: The law requires that the death certificate be executed DSC burial-trar Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗷 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 12 years 1☐Yes 2⊠ No 2 X No 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) nsisteet Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 6 Other (Specify) funerai 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a

To the Funeral I 1 detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar

29b. Signature and title of certifier

Jr. Bushra 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 2 6

30. Name and address of person who completed cause of death (Hem 23a) (Type, Print),

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** VIRGINIA LEE ALIFF <u>3:</u>25 P <sup>M</sup> 25. JUNE 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner CARROLL LORIEN NURSING CENTER TANEYTOWN If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 X F Yrs. 74 234-48-3960 9/23/1932 Director WEST VIRGINIA Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show at 1X Yes 2 No notified Director MD CARROLL WESTMINSTER 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code be r 23a 330 ROYER RD. 21158 USA 7 is marked other than "natural", or items 23s traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2∑ No If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) filed withir Hygiene. NURSES AID HEALTH 10 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NICK STOVER ETHEL MAE ALBERTS ္ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun 306 MAYFIELD CT., WESTMINSTER, MD, 21158 - SON ROY ALIFF 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) MEADOW BRANCH CEM. 6/28/2007 WESTMINSTER, MD □ Donation Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMINSTER, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician metes teti STOMACH months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transi be executed Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year for in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) ed by the a detached f P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 2 1∐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 1 Descritiying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 43643 . 24.07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tracutour uns 1 knows to. COFIS TATE Q.101 73000 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 6 Registrar 2007 PACKES

		1 - For State Registrar	State	of Marylai	•	artmen rtificat					giene Reg. No.	2007	2045
		1. Decedent's Name (First, Middle,	Last)						2	Date of Dea		Voor	3. Time of Death
Physici /Medic		Yolanda Andes								June 1	8, Day	007	1:00 PM M
Examin		4a. Facility Name (If not institution,	ive street and n	umber)		4b. City,	Town, or	Location of	of Death		4c.	County of Deat	h
		10516 Marriott	sville R	Road		Ran	dalls				:	Baltimo	re
Funeral Director		5. Social Security Number 218–26–1149	.Sex 1 □ M 2 🛱 F	7. Age (In yrs 96	. last birthday) Yrs.	If Under Months	1 Year Days	ff Under Hours	Min. Min.	Date of Birt (Month, Da) (ar 6,	1911	9. Birt Ma:	hplace (State or Foreign untry) ryLand
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sath	erai		_	cedent Ever in l	10 12 1	Man Door			ain? (Speci	fy Yes or No-		14. Race - Ame	dean Indian
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Irs al	by	3 ₩ Widowed 4 Divorced	If Yes, C Year or	Sive		1 🗆 Yes	2 <b>X</b> No	Specify:				Specify: W	hite
2 hou	Completed	15. Decedent's			16a. Dece	dent's Usu	al Occupa	tion			16b. Kii	nd of Business/	Industry
hin 7	ple	(Specify only highest Elementary/Secondary (0-12)		(1-4or 5+)	(Give	kind of wo DO NOT u	rk done di se retired)	uring mos	t of working	'			
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and 2 sho ealth and 1 m 27 is ma		19a. Informant's Name/Relationship Tom Andes/son	(Type, Print)			•				Route Numbe urg, M		r Town, State, 2 21784	(ip Code)
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mendal Hygiene. Department of Health and Mendal Hygiene. Important: If them 27 is marked other than "natural; or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be nuithed as once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ※Donation 5 ☐ Other (Spe		-	Place of Dispo cemetery, crer	sition (Nai natory or d	me of other place	)	Dat	le	20c. Lo	cation - City or	Town, State
permit. I Departm Importa any inju		21. Signature of Euneral Significant		irecto	-	ate a		•	Bard 6	655 W.	Bal	timore	Street
Pnysician		23a. Part Enter the disease, or conshock or heart failure. List of Immediate Cause (Final disease or condition	emplications that by one cause on	0		er the mod		, such as		respiratory ar	rest,		Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)  Sequentially list conditions,	Due to	o (or as a conse	quence of):		•						J
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icate be executed physician and sthe burial-transit	dical Ex	resulting in death) Last	Due to	o (or as a conse	quence of):								
ertifica ling pl		IF FEMALE:											
To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  On the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ysician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 █ No 9 ☐ Unknown	1 🗆 Live	outcome of pregrebinth 2 Fet grant at time of thought	al death 3	Ectopic p Other (sa					2	23d. Date of del Month	ivery Day Year
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al or Attending Ph after death. Director: After th d in by the funeral	Certification:	3 Suicide 6 Could no 4 Homicide determin	289. Plat	ce of Injury - At I	home, farm, str ify)	eet, factor	y, office		28	f. Location (S City or Tow			ıral Route Number,
Little Hospital or Attendin within 24 hours after death. To the Funeral Director: All completely filled in by the fur	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the aminer: On the and ma	he best of my kn basis of examin inner stated.	owledge, death	occurred vestigation	at the time, in my op	e, date an inion, dea	d place, an	d due to the d I at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
To th Mithin Fo th	Me	29b. Signature and title of certifier				29	c. License	number			29d. Dat	e signed (Mont	h, Day, Year)
. >= 0		) the	- n	D		1	243	152	-		50/	ne 20.	7007
		30. Name and address of person w		use of death (Ite	om 23a) (Type,	Print)	ce Ad	. #	135			MD 71	
Sta		31. Date filed (Month, Day, Year)		Registrar's Sign		Ø							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend #20b per FH G868 6/26/07 artificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 18ay 3. Time of Death **Physician** Bahadur Bhandar 1:20 PM 2007 6 /Medical 4a. Facility Name (If not institution, give street and number).

Franklin Square Hospt 4b. City-Town, or Location of Death 4c. County of Death Examiner osedale Baltimore DHa If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number Age (In vrs. last birthday Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**X** M 2□ F 75 Unknown Director August 27,193 1 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show injury or other traumatic event, the Medical Examiner must be notified at MO Parkville 1 ☐ Yes 2 No Director Baltimore 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 96 Nepa Cedar Chip Court "natural", or items 23a 21234 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: nepalese 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) and 2 should be filed withir ealth and Mental Hygiene. Dergeant British Armi 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bhandari Pompha himda 1). K. C 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Court Parkville MD permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trau Ram Bhandari Cedar Chip Son 6 21234 6/23/2007 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Evanstune ral chape 1 Forest Hill:MO 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Evans funeral chape and Cremation Serving 3 Newport Orive Forest Hill, 21. Signature of Funeral Service License Blacketon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Hemmorhige Wyentriewar extension Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner on Coumadir Fibrillation certificate be executed and Due to (or as a consequence of) Records, P.O. Box 68760 physician Physician/Medical as the attending I 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 Other (specify) □Yes 2□No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 1□ Yes Division or Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 217 No Hospital: 1 Inpatient မ 1 Tes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manher of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 5 ☐ Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Funeral hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only 24 and manner stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 ame and address of person who completed (au se of death (Item 23a) (Type, Print) Franklin Square Drive Balto. aky Joseph

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

JUN 2 6 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #5 Per FH C868 6/26/00 entificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Z3 Year Brown 00 35 AM Katherine -inda /Medical 6 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN Square HOSPITAL CENTER Rosedale BALTIMON & 5. S220-54-12900 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 57 5-1-29 Director May 29, Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Baltimore Count Director Maryland Carne 1 ☐Yes 20 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 9912 Finner United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ Specify: White 3 ☐ Widowed 4 N Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Me Elementary/Şeçondary (0-12) College (1-4or 5+) Merry Go Round ware house Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Beck Doris Weiner 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Driscall Rd, Belair, Md. Danie 5. Shamrock 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c, Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 36/07 Chapel Forest Hill, Marylar P 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Services TOVA Baltimore, maryland 31234 8800 Hartord Rd 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** FaiLure RespiraTory

Due to (or as a consequence of): /Medical **Examiner** COPD / ARDS/ Pheumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duc to (or as a consequence of): LIVER FaiLure burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical ALCOHOLIC cirrhosis IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) n signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy perform 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: the Hospital or Attending hin 24 hours after death. 5 ☐ Pending investigation 1 Natural thin 24 hours after uses...

o the Funeral Director: Af 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Fune (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Mara

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

FRANKLIN

9000

32. Registrar's Signature

Square DRIVE

BALTIMORE

			For State Registrar	State of Marylar		artment of Health and rtificate of Death		giene 07	20457
			Decedent's Name (First, Middle, I	ast)			2. Date of Dea	ith	3. Time of Death
	Physici		Dorothy	BRATCHE	e		Month	Day Year	- 10'NO 7 M
j.	/Medic Examin		4a. Facility Name (If not institution of	nive street and number)		4b. City, Town, or Locetion of D		4c. County of Dea	
	Examin		UNION MEM	orial Hospia	MAL	BALTIMOR	e		
	Funeral			. Sex 7. Age (In yrs.		If Under 1 Year   If Under 24 I	Hrs. 8. Date of Birtl	9. Bi	rthplace (State or Foreign
	Director		216-18-8939	1□M 2XF	33 Yrs.	Months Days Hours A	Min. (Month, Day 04-11-	1924 M	ARYLAND
7			Usual Residence of Decedent				<u> </u>		
6	bow i		10a. State 10b. County		ity, Town or Lo				10d. Inside City Limits
2		cto	MD		BALTI	MORE			1 Yes 2 No
4	or 28	Director	10e. Street and Number			10f. Zip Code		10g. Citizen of What C	ountry?
book od die die	23a or 28e-f ehow		110 N. CENTI	ear AVENU	IE	21202		U.S.A.	
		Funerai	11. Marital Status	12. Was Decedent Ever in U Armed Forces?		Was Decedent of Hispanic Origin? f Yes, specify Cuban, Mexican, Pi	(Specify Yes or No- uerto Rican, etc.)	14. Race - Am Black, Wh	
9	a a a		1 Never Married 2 Married	1 □ Yes 2 No		1 ☐ Yes 2 No Specify:	, ,		BLACK
1215-0036	stural, or Iteme	d by	3 Widowed 4 Divorced	Year or Dates:					
<u>,                                    </u>	n and	Completed	15. Decedent's (Specify only highest of		(Give	dent's Usual Occupation kind of work done during most of	working	16b. Kind of Business	s/Industry
2	9 c 4	m m	Elementary/Secondary (0-12)	College (1-4or 5+)	A Jan	DO NOT use retired) RSE'S ASSISTI	ANT	HEALTHO	CARE
7			17. Father's Name (First, Middle, La	ct)	IVUI		Name (First, Middle,	Maiden Sumame)	
anc	ntal Hyg ed other	Be	1100 70				ia TAYL	_	
Maryland 21	d Me nark natic	2	HARIM BATCH  19a. Informant's Name/Relationship		10h Mailie	ng Address (Street and Number of			Zin Code)
Z Z	h and 7 le r		Byron Brown			V. EUTAN PLA			
	Healt em 2 ther		20a. Method of Disposition			sition (Name of	Date	20c. Location · City o	
Baltimore,	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		1 SeBurial 2 ☐ Cremation 3	Removal from State	cemetery, crer	natory or other place)  DGE CEMERY		,	
	Deportment Important:		4 Donation 5 Other (Spec						
Ba	mp my nny		21. Signature of Funeral Service Lic	all I. Mass		Name and Address of Facility			
	10144		Total B. Dy	70,1100		000 E. BALTIN			
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	ly one cause on each line.	ith. Do not ent	er the mode of dying, such as care	diac or respiratory ari	rest,	Approximate Interval Between Onset and Death
	hysician		Immediate Cause (Final disease or condition	_a Sepsis	S				724 hours
	/Medical xaminer		resulting in death)	Due to (or as a consec	quence of):				05-040-5
	.xummer		Sequentially list conditions	, Metast		Breast Carci	noma		71 400
. /	sit s	lue	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence or):				9
V	and I-tran	Examine	that initiated events resulting in death) Last	c Due to (or as a consec	guence of):				
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80	phys the	dicai	1	d					
9X 65	ettending pl	Physician/Me	IF FEMALE:	23c. If yes, outcome of pregn	ancv			22d Date of de	Nis con .
Box	etten for u	ian	23b. Was decedent pregnant in the past 12 mopths?	1 ☐ Live birth 2 ☐ Feta	aideath 3□	Ectopic pregnancy Other (specify)		23d. Date of de Month	Day Year
. 7	, 0 2	ysic	1 ☐ Yes 2 ☑Ño 9 ☐ Unknown	9☐ Unknown	ueau s	Cirier (specify)			
ecords, P.O	deta		Part II. Other significant conditions	contributing to death but not re-	sulting in the u	nderlying cause given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
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Vital Records,	been si	Completed					_		
ě	hes ye 2	μ					24a. Was autop	sy prior to	utopsy findings available completion of cause of
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of Vita	certificete he	Be	25. Was case referred to medical examiner?	Hospital:		Othor	Death (Check only or		
5	this	. To	1 Yes 2 No	1 Inpatient 2L	JER/Outpatien 28b. Time of	1 3 DOA 4 1401311		ence 6 Other (Sp.	ecify)
	After funer	<u>e</u>	1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	Work? M 1 ☐ Yes 2 ☐ No	200. Describe ii	ow injury occurred	
VISION	ter death. irector: A ir by the fu	cai	3 Suicide 6 Could not	be 38e Blace of laive. At h	nome farm str		28f Location (S	treet and Number or F	Rural Route Number
= 3	표현교	Certification:	4 Homicide determine	building, etc. (Speci	ify)	cot, ractory, office	City or Tow	m, State)	
] leticoch	S E E	S I	29a. Certifier 1 Certifying	Physician: To the best of my kn	owiedae. death	n occurred at the time, date and pl	lace, and due to the	cause(s) and manner a	s stated
Ž.	24 h Fur etely	edical	(Check only Dedical Ex	aminer: On the basis of examination and manner stated.	ation and/or in	vestigation, in my opinion, death of	occurred at the time, of	date and place, and du	e to the cause(s)
To the	within 24 ho To the Func completely f	Me	29b. Signature and title of certifier	1		29c. License number		29d. Date signed (Mor	nth, Dey, Year)
,	> - 0		) (WX c	+1	-	A C. C. L.		Time 3	2667
	2		30. Name and address of person wh	to completed cause of death (Ite	m 23a) (Type.	AT243894	9	June 20,	2001
	9		Quintina. L.	Benson, mi		gione Memorial	Hospital	Buttimore	mÞ
	Sta	te	31. Date filed (Month, Day Khar)	32. Registrar's Sign		parte	1 loops lock		1
	Registr			The state of the s	- 0				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2140 am James 25 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Richey 10seph Hospice If Under 1 Year | If Under 2 Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) Social Security Number **Funeral** Days **1X**M 2□ F 78 216.20.5464 Yrs. MD 611 30 1929 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show "natural", or items 23a or 28a-f shov idical Examiner must be notifled at 1 XYes 2 □ No Baltimore MD Director 10g. Citizen of What Country? 10e. Street and Number 21205 USA Benil Henue Funeral 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 MYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Black Baltimore, Maryland 21215-0036 ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) Graphic Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Worker Communications Stharade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name First, Middle, Last) Anna Warren Charles Bell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sister Delores 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Owings Mills, MD gamoon torest 07/03/07 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Vaughn C. Greene Funeral SVCS 21. Signature of Funeral Service Licensee York Read m01363 4915 Baltimore MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immufact cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 No 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of DiJease 24a. Was an autopsy performed? Yes 25/No death? 1 ☐ Yes 2 No 25. Was case referred to medical examiner?
1 Yes 25 No filled in by the funeral director, 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Deter (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA HOSPICE Medical Certification: To within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director. 28a. Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27, Manner of Death (Month, Day Year) Injury 1 Natural 5 ☐ Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H0064267 6-25-01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) inden Av Baltimore, MD. 21201 Karen Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JUN 2 6 2007

07-04805 Joshua A Brand

death with the Maryland

72 }

Baltimore, MD 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Deat Physician/ Month Day June 24, 2007 1757 hrs **Medical Examiner** Joshua Adam Brand 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** Johns Hopkins Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Country) Days Hours Director 053-68-1007 25 AUG 20 1981 NY 1 XM 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 X Yes 2 No N/A Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3624 Esther Plac Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 X Never Married 2 Married 2 X No Yes Yes 2 X No specify: White 4 Divorced If Yes Give Year Specify: event, the Medical Examiner à 16b. Kind of Business/Industry Plumbing & 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) nit. Pages I and 2 should be filed within 72 h arment of Health and Mental Hygiene. ortant: If item 27 is marked other than "m: ry or other traumatic event, the Medical Ex Elementary/Secondary (0-12) College (1-4 or 5+) Steamfitting 3 Journeyman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis Brand Joan Μ. - Giganti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan M. Brand-King - mother 17 Sturbridge Lane, Stafford, VA 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc. 6/29/2007 Baltimore, Donation 5 Other Specify <sup>22</sup> MacNabb Funeral Home, P.A. 301 Frederick Road, Catonsville, 21. Signature of Funeral Se Steven H. Williams Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /ivicaicai Death a. Asphyxia Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of): b. Hanging Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical AMENDED UNPENDED 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live hirth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> Yes 2 ✔ No 3 Probably 4 Completed 24b. Were autopsy findings available 24a, Was an autopsy prior to completion of cause of performed? Yes 2 V No Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: examiner? Other<sub>4</sub> Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 Yes Certification: To a. Date of Injury (Month, Day, Year) DUND: 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury Subject hanged self FOUND: Yes 2 V No

signed by the attending physician and be detached for use as the burial - tran the Hospital or Attending Physician: The law requires that the death certificate behin 24 hours after death. Division of Vital Records, P.O. Box 68760, After this certificate has been if funeral director, page 2 should To the Funeral Director: completely filled in by the

27. Manner of Dea	th	28a. Date	of Injury	28
1 Natural	5 Pending	FOUND:		F(
2 Accident	Investigation			
3 🗸 Suicide	6 Could not be		of Injury - At h	
4 Homicide	determined	(Specify)	Single Fan	nily
29a. Certifier	Certifying Physician:	To the bes	of my knowled	ge,

29b. Signature and title of certifier

31. Date filed (Month,

n 24, 2007 1730 hrs

e. Place of Injury - At home, farm, street, factory, office building, etc

29c. License number

O.C.M.E

28f. Location (Street and Number or Rural Route Number, City or Town, State) 3624 Esther Place, Baltimore, MD

the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

June 25, 2007

29d. Date signed (Month, Day, Year)

	/	7060	ne	100	wo	24	100			
30.	Νá	me and	addr	ess of	person	who c	ompleted	cause of	death (Iter	m 23a)
	M	elissa	Bra	ssell	, MD	As	sistant	Medic	al Exami	iner

and manner stated

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner

32. Registrar's Signature

State Registrar

Medical

Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 **Physician** Month Year Mary Ann Buonomo June 20, 10:09 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8599 Manorfield Rd Perry Hall Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 💢 F Director 218-80-9876 39 12-07-1967 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygene.
Important: If them 27 is anawled other than "natural", or items 23a or 28a-f show any Injury or other traumalle event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8599 Manorfield Rd 21236 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2X Married ☐ Yes 2 Yes, Give 2**X**] No 1 ☐ Yes 2 🔀 No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ John Buonomo Joan Ay 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric Supensky (Husband) 8599 Manorfield Rd Perry Hall, MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State Gardens of Faith 4 ☐ Donation 5 ☐ Other (Specify) 06-23-2007 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licensee 9705 Belair Rd Baltimore, MD 21236 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin. Immediate Cause (Final disease or condition resulting in death) **Physician** LEONA /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter or darrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 4□Pregnant at time of death 5 Other (specify) þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has le 2 autopsy perforn certificate 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 Ho Hospital: Other: 4 Nursing Home ပ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Aresidence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury 28b Time of Certification: 28d. Describe how injury occurred 1 Natural
2 Accident (Month, Day Year) 5 Pending investigation 1 Yes 2 No I Director: 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I Pcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2007 10 PAUL (Plans, M) (669 N. (Type, Print) BA June Mo

State Registrar 31. Date filed (Month, Day,

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760,

OMONO

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2007 **Physician** 0058 William G. Black, Jr. June 21, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Upper Chesapeake Hospital Harford Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F Director 216-36-3433 68 10-08-1938 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 X No Director Bel Air Maryland | Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1545 Helmsdale Rd 21015 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☑ Married  $\frac{(e/\mathcal{Z}_1/\mathcal{Q}_7)}{4}$  Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify δ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) Machinist AT&T is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental William G. Black Sr. Mary M. Lazarro 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 i Victoria Black (Wife) 1545 Helmsdale Rd Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holly HI11 06-25-2007 Middle River, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Signature of Juneral Service License Schimunek Funeral Home of Bel Air 516 Inc. 610 W. MacPhail Rd Bel Air, MD 21014 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final utropenic days **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): months Examiner grade mueloc if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Box 68760. Physician/Medical as attending properties of the second 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 11. am 81ack, Sr. Division or Vital Records, P.O. ed by the 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform certificate 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

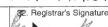
To the Funeral Director: After to completely filled in by the funeral Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or 1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0

10

State Registrar

31. Date filed (Month, Day, Year)

JUN 2 6



BAHRANI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHKAN

ature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day **Physician** Year Robert W. Bauernschmidt 2:22 PM 2007 20 /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner FRANKlin RosedAle BAITIMORE QUARE 8. Sex HOSDIJA If Under 1 Year | If Under 24 Hrs. Funeral Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1**∑**M 2□ F Months Min. Director 219-58-3135 56 11-22-1950 Maryland Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or any injury or other traumatic event, the Medical Examiner must be no 9509 "P" Kingscroft Terrace 21128 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Vice President Beverage 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental I int: If item 27 is marked of William Bauernschmidt M. Helen Rau 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9509 "P" Kingscroft Terrace Perry Hall, MD 21128 Rosalyn Seegard (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buria! 2 Cremation 3 ☐ Removal from State 06/25/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licenses 9705 Belair Rd Baltimore, MD 21236 un Ce 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) 11 Hours /Medical Examiner STATIC if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown this certificate has been siral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1 Yes 2N No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation Year) within 24 hours after death.

To the Funeral Director: A completely filled in by the ft 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 0 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State

NSCHMI

21215-0036

Maryland

Baltimore,

Division or Vital Records, P.O. Box 68760,

Registrar

0

29b. Signature and title

DR Jose 31. Date filed (Month, Day, Year)

of certifier

Lopez

JUN 2 6 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000

FRANKLIN

. Registrar's Signature

29c. License number

D0054725

SqUARE DR. BALTIMORE Md 21237

29d. Date signed (Month, Day, Year)

			4 101	epartment of Health and M Certificate of Death	ental Hygier	001177	20463				
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Doris Elizabeth Bohlen		June		3. Time of Death 4:55 P				
	Examin	er	4a. Facility Name (If not institution, give street and number)  8343 Pulaski Highway	4b. City, Town, or Location of Death  Roseda1e	4	tc. County of Death Baltin	nore				
A S	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☑ F 83	(ay) If Under 1 Year   If Under 24 Hrs.   Months Days Hours Min.	8. Date of Birth (Month, Day, Yea July 27,		ace (State or Foreign try) ginia				
	aryland show d at		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of			10	Od. Inside City Limits				
	in the Ma or 28a-f	Director	Maryland   Baltimore     10e. Street and Number	Rosedale 10f. Zip Code	10g. (	Citizen of What Coun	1 ☐ Yes 2 No try?				
	23a cust be	ralD	8343 Pulaski Highway	21237		U. S. A					
336	be filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2 ☑ No Specify:	cify Yes or No- Rican, etc.)	14. Race - America Black, White, e Specify: Whi	etc.				
21215-0036	iin 72 hou n "natura Medical E	Completed	(Specify only highest grade completed) (G	ecedent's Usual Occupation live kind of work done during most of workii fe. DO NOT use retired)	ng 16b.	Kind of Business/Ind					
212	ed within giene. er than " , the Mec	Com	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker		Own Home					
Maryland	ould be filed v Mental Hygie arked other I atic event, th	Be	17. Father's Name (First, Middle, Last)		(First, Middle, Maid	,					
ΪŽ	2 should be and Mental is marked of aumatic ev	2	James K. Shiflett  19a. Informant's Name/Relationship (Type. Print)  19b. N	Minnie  Address (Street and Number or Rura	R. Morri		Code)				
	aff 27		Barbara Bohlen (Daughter) 25	580_Hill Road, Green	•						
ore	0 0		20a. Method of Disposition 1 IX Burial 2 □ Cremation 3 □ Removal from State  20b. Place of D cernetery,	crematory or other place)		Location - City or To					
Baltimore,	permit. Pag Department Important: I any injury o		4 ☐ Donation 5 ☐ Other (Specify) Gardens 21. Signature of Funeral Service Licensee.	s of Faith 06/2 22. Name and Address of Facility Sch		ltimore, M					
Ba	Dep Imp any		Buin a. Verelle	9705 Belair Road, B							
T.	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death 30-60 min				
8760,	/Medical Examiner  hysician and the prital-transit	ysician/Medical Examiner	ical			ical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	ARDIAL INFARET CARDIOVASCULAR D	ISEISE		> 10 YRs
P.O. Box 687	eath certific attending p for use as f				IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	ry Day Year		
	w requires that the de been signed by the should be detached	ed by PI	Part II. Other significant conditions contributing to death but not resulting in the HYPERTENSIVE CAPDININGSCUAR D	- 0		o use contribute to th 2 No 3 Prob	e cause of death? ably 4 □Unknown				
Records,	9	Completed by	HYPERLIPIDEMIA PLEURAL EFFUSSION		24a. Was an autopsy performed?	prior to con death?	osy findings available inpletion of cause of				
Vital	sician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?	26. Place of Death	1 Yes 2 (Check only one)	¶o 1 □Yes	2 No				
Division or V	y s	2	1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outps  27. Manner of Death 1   Natural 5   Pending   (Month, Day Year)   Inju 2   Accident   Ac	e of 28c. Injury at 2	ne 5 PResidence 28d. Describe how in	6 ☐Other (Specify jury occurred	)				
Divisi	al or Atter after dea I Director d in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rura ate)	Route Number,				
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, decided in the past of examination and/cand manner stated.	eath occurred at the time, date and place, a r investigation, in my opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as st and place, and due to	ated. the cause(s)				
	To the within to the company of the	Ž	29b. Signature and title of certifier  Machine Grant Common And Machine Common And Machin	29c. License number  DOD 150 2 2	29d. [	Date signed (Month, I	Day, Year)				
	ń		30. Name and address of person who completed cause of death (Item 23a) (Ty TEODULD PAGLINAUAN, MD. 617	DO015022 pe, Print) DEMMERS RUN RD.,	SIE-E; E	BALTO., L	1021221				
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 2 6 2007	uli							

		•	For State Registrar	State o	f Maryland	l / Depa <i>Ce</i> a	artment of F rtificate of	lealth an <i>Death</i>	d Mental Hy	giene Reg. No	Some Service of	20464
	Blooming		1. Decedent's Name (First, Middle, La.	st)	_	7			2. Date of D Month	eath Da	y Year	3. Time of Death
	Physicia /Medic		Marie C. Bayer	•					June	21, 2	2007	12:05 P M
1	Examin		4a. Facility Name (If not institution, give		mber)		4b. City, Town, o	r Location of D	eath		County of Deat	
			Holly Hill Mano		7 Ann (In um In	na foliado do ci	Towson If Under 1 Year	If Under 24	Hrs Q Data of Bi		11timore	
	Funeral Director		212-74-2300	-M 2∏ F	7. Age (In yrs. Ia 100	Vro	Months Days		Hrs. 8. Date of Bi (Month, D 06-10-	ay, Year) 1907	Mary	hplace (State or Foreign untry) 1and
	and and	}	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	ocation					10d. Inside City Limits
	r 28e-f ehow	to	Maryland Baltimo	re	Tows	son						1 ☐ Yes 2 🕅 No
	ith the	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Cit	izen of What Co	untry?
	23a c	aiD	531 Stevenson Lar	ie			21286			U.S.	Α.	
	ter des iteme	ruel	11. Marital Status	Armed Fo		. 13.	Was Decedent of H If Yes, specify Cubi	lispanic Origin an, Mexican, P	? (Specify Yes or Nuerto Rican, etc.)	0-	14. Race - Ame Black, White	
36	g 9	by Fi	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1 ∐ Yes If Yes, Gi Year or D	ve		1 ☐ Yes 2 🎇 No	Specify:			Specify: W	Mhite
9	72 hours "natural", dical Exe	ted	15. Decedent's Ed	lucation		16a. Dece	dent's Usual Occup	ation		16b. K	ind of Business/	Industry
215	c * 38	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (		(Give life.	kind of work done DO NOT use retired	during most of d)	working			
21	filed wit Hygien ther the	Con	12			Housev	vife			1	Home	
Maryland 21215-0036	should be filed within od Mental Hygiene. marked other then imatic event, It a M	Be	17. Father's Name (First, Middle, Last) Charles Rivers						Name (First, Middle ia Hoffmat		Sumame)	
Z Z	d Mer marke	ဥ	19a. Informant's Name/Relationship (	Type Print)		19h Maili			or Rural Route Numi		r Town State 7	in Code)
Ma	th an		Robert Bayer (Sor				•		tsborough	-	Labama 3	
ē,	Hea Hem		20a. Method of Disposition			ce of Dispo	sition (Name of matory or other place	T	Date	-	ocation - City or	
E O	Page ient o nt: ff ry or		1 ☐ Burial 2 🕅 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		State	-	Crematory		-22-2007	Balt	imore,	Maryland
Baltimore,	permit. Pages 1 end 2 should by Department of Health and Menta important: if item 27 is marked eny injury or other treumatic evone.		21. Signature of Funeral Service Licer	isee *	Δ,	0.0	Name and Added	an of Families	Schimunak			
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			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that one cause on e	caused the death.	Do not ent	er the mode of dyir	1				Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a/	End?	St	290	1)	ment i	1		Oriset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conseque	ence of):						
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a conseque	ence of):						
X	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C								
, ·	cate be executed physicien and the burial-transit	Exa	resulting in death) Last	Due to	(or as a conseque	ence of):						
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_			IF FEMALE:	220 15 1100 011	tcome of pregnan	014						
Вох	death certific e ettending p id for use as	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐Live t	pirth 2 ☐ Fetal on the present at time of dea	déath 3[	Ectopic pregnancy Other (specify)	1			23d. Date of deli Month	ivery Day Year
P.O.	0 0 2	Physician/M	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unkn		1111 3						
	requires that the een signed by th hould be detache	by P	Part II. Other significant conditions of	ontributing to d	eath but not result	ting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
Vital Records,	w require been sig should bi								_ 1□	Yes 2	□No 3□Pr	obably 4 Unknown
900	aw is b	piet							24a. Wa		24b. Were au	topsy findings available completion of cause of
æ	0 - 0	Completed							peri 1 🗆 Yes	ormed?	death?	1
/ita	ucian: Th certificete rector, pag	Bec	25. Was case referred to medical examiner?						Death (Check only	one)		
of \	Physician: this certific ral director,	၉	1 ☐ Yes 2 No			R/Outpatier		4 Nursir	ng Home 5 ☐ Res			cify)
	te diameter	lon	27. Magner of Peath 1 Natural 5 Pending		of Injury oth, Day Yeer)	28b. Time o Injury	Wor	yat k? Yes 2 ∐ No	28d. Describe	how inju	ry occurred	
Division	Attending r death. ector: After by the fune	ficat	Accident investigation  3 Suicide 6 Could not b		of Injury - At hom	ne, farm, sti		163 2 110	28f. Location	(Street ar	nd Number or Ru	ıral Route Number.
Ö	after Dire d in b	Certification;	4  Homicide	build	ing, etc. (Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or To	wn, State	)	
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the to	edicai C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	niner: On the b	e best of my know pasis of examination of stated.	ledge, deat on and/or in	h occurred at the tir vestigation, in my o	me, date and p pinion, death o	place, and due to the occurred at the time	cause(s , date and	) and manner as d place, and due	stated. to the cause(s)
	To th within sompl	Me	29b. Signature and title of certifier	)		2	29c. Licens	e number		29d. Da	te signed (Monti	n, Dey, Year)
				/	IM	7)	DOOG	56779	5	00	01221	107
	h		30. Name and address of person who	completed caus	se of death (Item)	ada) (Type,	Print)	0 1	00-7			
	7		Hasha Morad	MI.D.	1505	3160	r Unix	501	T,806 37	Cong	on, mr	POSIG (
	Sta Registr		31. Date filed (Month, Day, Year)	7 32. F	Registrar's Signatu	1re /284	Es .					

			For State Registrar	State of Ma	rylan		irtment of				()		201.65
	Physici	ian	Negistrar     Necedent's Name (First, Middle, Last,     Maxine L. Balko	)				Dean		2. Date of Dea		Year	3. Time of Death
	/Medic Examir	cal	4a. Facility Name (If not institution, give	street and number)			4b. City, Town	or Location	of Death	00-22-2		ounty of Death	6:00 A M
	or and other three transfers	ш	5138 Wright Ave					1timo:					
	Funeral Director		5. Social Security Number 6. Security Number 188–20–8237	]M 2√27F	(In yrs. ) 81	last birthday) Yrs.	If Under 1 Year Months Day		Min.	8. Date of Birth (Month, Day June 6	v, Year)	Cou	place (State or Foreign ntry) ISY1vania
	and		Usual Residence of Decedent  10a. State 10b. County		10c City	y, Town or Lo	cation						10d. Inside City Limits
	Maryla a-f sho	ţo	Maryland N/A	A		timore							1 X Yes 2 □ No
	death with the Maryland rms 23a or 28a-f show r must be notified at	Direc	10e. Street and Number 5138 Wright Avenue				10f. Zip Code				10g. Citizer	n of What Cou	ntry?
	be filed within 72 hours after death with the Marylar that Hygiene.  dother than "natural", or flems 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?		S. 13. V	Vas Decedent of Yes, specify Cu		rigin? (Spe	cify Yes or No- Rican, etc.)	14.	. Race - Ameri Black, White,	
020	ours afte ral", or I Examin	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1	0	1	□Yes 2XIN	o Specify	<i>r</i> :		S	pecify: Whi	ite
21213-0030	d be filed within 72 hours after de antal Hygiene. ted other than "natural", or ftem c event, the Medical Examiner n	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e co <i>mpleted)</i> College (1-4or 5+		16a. Deced (Give life. L	ent's Usual Occ kind of work don OO NOT use retii	upation e <i>during mo</i> re <i>d</i> )	st of worki	ng	16b. Kind	of Business/Ir	ndustry
7	ed with ygiene er tha t, the I	Com	8	College (1-401 54	,	Shee	t Metal					Martin	S
/land	ontal Hyeed oth	Be	17. Father's Name (First, Middle, Last)					18. Moth		(First, Middle,		rname)	
5	2 should be and Menta is marked raumatic ev	P.	Samuel Mathews  19a. Informant's Name/Relationship (Ty	pe. Print)		19b. Mailin	g Address (Stree	et and Numb		Chilcoa Il Route Numbe		own, State, Zi	p Code)
, <u>S</u>	and 2 saith a n 27 is er trat		Judy Balko (Daught	er)		5138	Wright	Avenu					
ore Ore	permit. Pages 1 and 2 should be Department of Health and Mente Important: If item 27 is marked any injury or other traumatic es		20a. Method of Disposition 1 ABurial 2 □ Cremation 3 □ F	Removal from State	1_		sition (Name of natory or other p			ate		tion - City or T	
Dallinor	artmer ortant injury		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	ee	Gar	rison 1	. Name and Add				_		Maryland
۵	permi Depar Impor any ir		* HI Ella				05 Bel A						;
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishook, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the cause on each line cause on each line a.  Due to (or as a	ry	94	er the mode of d			r respiratory ar	rest,		Approximate Interval Between Onset and Death
,00,0	ate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	· ·	<u> </u>			-				***************************************
O DOX O	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal	Ideath 3□	Ectopic pregnar Other (specify)	су			23d	I. Date of deliv	ery Day Year
L 'S'	uires that signed t d be deta	by	Part II. Other significant conditions cor	1		ulting in the un	derlying cause g	iven in Part	l.	23e. Did to			the cause of death?
ecords,	law requas been 2 shoul	Completed	lypertensi							24a. Was a	an 2	24b. Were auto	opsy findings available ompletion of cause of
<u> </u>	icate h		0.9		_					perfor	med? 2 No	death?	2□ No
N II A	siciar certif irector	Be C	25. Was case referred to medical examiner?	lospital: 1 ☐ Inpatien		ER/Outpatient	3 DOA O	thor:		(Check only or			
5	ig Phy ter this neral d	n: To	27. Manner of Death	28a. Date of Injury	,	28b. Time of	28c. Inj	4 LIN	1	ne 5 Resid 28d. Describe h			fy)
	r Attendir ter death. irector: Af irector: Af	Certification:	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide 1 Homicide 1 Pending (Month, Day Year) Injury Work?  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street City or Town, Street)									lumber or Run	al Route Number,
כ	tospital of thours af annual of the filled in the filled i		(Check only 2 Medical Examin	sician: To the best of	my knov	wledge, death	occurred at the	time, date a	ind place, a	and due to the o	cause(s) an	id manner as s	stated.
	o the hithin 24 o the F	Medical	one) 29b. Signature and title of certifier	and manner state	ed.			nse number				igned (Month,	
	FSFÖ		NA	u D			Doc	338	97		6/2	2/07	>
	8		30. Name and address of person who co		ath (Item	23a) (Type, F	Dot Print)	Au	r B	a (time	e - + ;	MD, S	1224
	Sta		31. Date filed (Month, Day, Year)	32. Registrar	's Signat		0.00						

			1 _ For State	orato of Marylan	id / Department of Health and I	Mental Hygier	ne	
			Registrar		Certificate of Death	Reg.	No. 711 7 7 1, 6	
	Physic	ian	Decedent's Name (First, Middle, L			Date of Death     Month	Day Year 3. Time of Dea	ith
1,8	/Med		4a. Facility Name (If not institution, gi	rivens	4.00.7	June a	4 2007 333	4 м
	Exami	ner		ve street and number)	4b. City, Town, or Location of Death	1	4c. County of Death	
	Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs.	last birthday) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or For	
t	Director		219-22-0536	1 M 2 SF 80	Yrs. Months Days Hours Min.	(Month, Day, Yea	(Country)	reign
	and *		Usual Residence of Decedent  10a. State 10b. County	10-02		1 100127	1921 maryland	1
	f sho	5	md Pra	Toc. Cir	y, Town or Location		10d. Inside City Lin	/
	the N 28a-i notifii	rect	10e. Street and Number	temore			1 □Yes 2 🖪	No
	3a or	Funeral Director	1525NI K	Ollina Pa	10f. Zip Code	9 109.0	Citizen of What Country?	
	deat	nerg	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - American Indian,	
36	be filed within 72 hours after death with the Maryland tal Hygiene. Ad other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	y Fu	1 Never Married 2 Married	1 Yes 2 No	If Yes, specify Cuban, Mexican, Puento 1 ☐ Yes 2 ☐ No Specify:	Rican, etc.)	Black, White, etc.	2
5-0036	hours tural	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:	5 3 5 6 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7		Specify: DO	
15	in 72 n "na" fedic	Completed	15. Decedent's E (Specify only highest gr	ade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king 16b.	Kind of Business/Industry	
2121	d within giene. ir than " the Mec	E	Elementary/Secondary (0-12)	College (1-4or 5+)	U.S. Postal (110)	Rec	S. Fostac	
р	e file al Hyg othe vent,	Be	17. Father's Name (First, Middle, Last	)	18. Mother's Nam	e (First, Middle, Maide	en Surname)	
Maryland	should be ind Mental marked o	10	Cornelius K	Divens	Ad	f T	ones	
lar	2 sho and Is ma		19a, Informant's Name/Relationship	(Type. Print)	19b. Mailing Address (Street and Number or Run	ral Route Number, City	or Town, State, Zip Code)	
	ges 1 and 2 should it of Health and Mer If Item 27 Is marke or other traumatic		trancine Ka	ey-nice	8242 Church Lane	Apt I. Bac	to, md, 21244	
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	emetery, crematory or other place)	}	Location - City or Town, State	
풀			4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice		00.002	0-07 A	-butus ind.	
ä	permit. Departr Importa any Inje		and a service Lice				on Riss Brito, MD 21.	999
i,	A Della		23a. Part1. E per the disease, or com	plications that caused the death	. Do not enter the mode of dying, such as cardiac	or respiratory arrest		
	Physician		shock r heart failure. List only Immedi & Cause (Final disease r condition	one cause on each line.	HOUD	or respiratory arrest,	Approximate Interval Between Onset and Death	
	/Medical		resulting in death)	a. Due to (or as a consequ	ence of):		71.	
3	Examiner		Sequentially list conditions, if any, leading to immediate	b	hm		7~1	
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68760,	tificate be executed Ig physician and as the burial-transit	edical	Cause (Disease or injury that initiated events resulting in death) Last	c				
		edical	Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant	cDue to (or as a consequence d	ence of):		23d. Date of delivery	
Box .		edical	Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 TM to	Due to (or as a consequence).  d.  23c. If yes, outcome pf pregnant 1 Live birth 2 Fetal of 4 Pregnant at time of decenters.	ence of):  ncy death 3 □Ectopic pregnancy		23d. Date of delivery Month Day Year	
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r Vital Records, P.O. Box	vysician: The law requires that the death certi is certificate has been signed by the attending director, page 2 should be detached for use a	ledical Certification: To Be Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Petal (a Defendence)  Petal (a Defendence)  Due to (or as a consequence)  Due to (or as a conseq	ence of):    Comparison	24a. Was an autopsy performed? 1 Yes 2 1 1 1 Yes 2 1 1 1 Yes 2 1 1 Yes 2 1 1 Yes 2 1 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 Yes	Month Day Year  use contribute to the cause of death?  2 No 3 Probably 4 Unknow  24b. Were autopsy findings availat prior to completion of cause of death?  1 Yes 2 No  6 Other (Specify)  ary occurred  and Number or Rural Route Number, e)  3) and manner as stated.  It place, and due to the cause(s)	nle
r Vital Records, P.O. Box	the Hospital or Attending Physician; The law requires that the death certiin 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending pletely filled in by the funeral director, page 2 should be detached for use a	ledical Certification: To Be Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown  Part II. Other significant conditions of the conditi	Due to (or as a consequence)  Due to	ence of):    Comparison	24a. Was an autopsy performed? 1 Yes 2 1 1 Yes 2 1 1 Yes 2 1 1 Yes 2 1 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 Yes	Month Day Year  use contribute to the cause of death?  Day Year  use contribute to the cause of death?  Day Year  use contribute to the cause of death?  24b. Were autopsy findings availate prior to completion of cause of death?  Day Occurred  On Other (Specify)  In Occurred  On Occurred  On Other (Specify)  In Occurred  On Other (Specify)  In Occurred  On Other (Specify)  In Occurred  On Other (Specify)  In Occurred  On Other (Specify)  In Occurred  On Other (Specify)  In Occurred  On Other (Specify)  In Occurred  On Other (Specify)  In Occurred  On Other (Specify)  In Occurred  On Other (Specify)  In Occurred  On Other (Specify)  In Occurred  On Other (Specify)  In Occurred  On Other (Specify)  In Occurred  On Other (Specify)  In Occurred  On Other (Specify)  In Occurred  On Other	nle
r Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical Certification: To Be Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown  Part II. Other significant conditions of the conditi	Due to (or as a consequence).  23c. If yes, outcome pf pregnant 1   Live birth 2   Fetal 4   Pregnant at time of des 9   Unknown  Ontributing to death but not result   28a. Date of Injury (Month, Day Year)  28e. Place of injury - At home building, etc. (Specify)  Visiclan: To the best of my knowliner: On the basis of examination and manner stated.	ence of):    Comparison of the content of the conte	24a. Was an autopsy performed? 1 Yes 2 1 1 Yes 2 1 1 Yes 2 1 1 Yes 2 1 1 Yes 2 1 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 Y	Month Day Year  use contribute to the cause of death?  I No 3 Probably 4 Unknow  24b. Were autopsy findings availat prior to completion of cause of death?  O 1 Yes 2 No  6 Other (Specify)  ury occurred  and Number or Rural Route Number,  e) and manner as stated. Id place, and due to the cause(s)  atteresting Month, Day, Year)	nle
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month /Medical <u>Charles W. Chaney</u> UNE 700S 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HOSPITAL ST AGNES BALTIMORE
If Under 1 Year | If Under 24 Hrs. N/A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1**X** M 2□ F 79 Yrs Director <u> 220-22-3605</u> 29, 1927 Sept. Maryland Usual Residence of Decedent a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Bristol Hill Ct. 21228 USA Items 23a "natural", or Items 23a Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. This the 23 mist; If item 27 is marked other than "natural", or Items 23 mist; If item 20 is marked other than "natural", or thems 2 mist no other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 □ Yes 2 □ No 1945 **-**If Yes, Give Year or Dates: 1946 Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Business Owner 17. Father's Name (First, Middle, Last) Meat Distribution 18. Mother's Name (First, Middle, Maiden Surname) Herbert P. Chaney Mary R. Wood 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important; if item 27 is any injury or other trat once. Mary Virginia Chaney, wife 1 Bristol Hill Ct. Catonsville, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Loudon Park Cemetery 06-27-07 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home, Inc. 23a. lant. Enter the disease, or complications that caused the death. Do not enter the mode of lying, such as cardiac a respiratory arrest, Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STROKE **Physician** 26 Hours /Medical Due to ( r as a consequence of): PERTENSION Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, STENOSIS LUMBAR 2 No 3 Probably 4 Unknown 1 Tyes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2[ Date of Injury (Month, Day Year) 1XYes 2□ No 2 ER/Outpatient 3 DOA Medical Certification: To ō 27. Manner of Death 1 XNatural 2 ☐ Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 24 hours after death e Funeral Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

15+1

ຮ State Registrar 31. Date filed (Month, Day, Year)

EL NOKUR!

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Alegistrar's Signature

MEDICAL

DHMH 17 Rev 1/2001

900 CATON AUE, BALTIMORE, ND 21229

DOCTOR

			For State Registrar	State of Ma		oartment of F ertificate of			ene 0 0 7	2453	
	Physici	an	1. Decedent's Name (First, Middle, La John B. Carl					2. Date of Death Month	24 20	3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution, gi			4b. City, Town, o	r Location of Death	6 24 2007 2:00 A M			
			713 Old St. Ma				sville		Harfo		
	Funeral Director		219-18-7272	Sex 7. Age 1XCXM 2 □ F	(In yrs. last birthda 81 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear)	Birthplace (State or Foreign Country) nnsylvania	
	land ow tt		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location	_			10d. Inside City Limits	
	a-f sh	ctor	MD Harfo	rd	Pyl	esville				1 ☐ Yes 2 X No	
	th with the 23a or 28 ist be not	Funeral Director	10e. Street and Number 713 Old St.	Mary's F	Rd.	10f. Zip Code 211	32	10g	g. Citizen of What USA	: Country?	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 Never Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 XYes 2 □ N If Yes, Give Year or Dates:	ver in U.S. 13	B. Was Decedent of H If Yes, specify Cub. 1 ☐ Yes 2X No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, Vhite, etc. white	
Maryland 21215-0036	ithin 72 ho ne. nan "natul Medical	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed) College (1-4or 5-	(Gir	edent's Usual Occup le kind of work done DO NOT use retired	during most of work d)	sing	6b. Kind of Busine	ess/Industry	
121	filed w Hygier ther th	Co	17. Father's Name ( <i>First, Middle, Las</i>	*)	t1	le worke		e (First, Middle, Ma	Constri	ction	
land	ild be f ental   rked or ic eve	To Be	Dorvan Carl	,				en Burge			
Aary	2 shou and N Is mai		19a. Informant's Name/Relationship			iling Address (Street					
	t and Health tem 27 other t		Joan C. Carl/ 20a. Method of Disposition	wile	20b. Place of Dis	position (Name of	:	Data as	Oc. Location - City	le, MP <sub>132</sub>	
Baltimore,	Pages ment of ant: If i		1 ☐ Burial 2 <b>T</b> Cremation 3 [ 4 ☐ Donation 5 ☐ Other ( <i>Spec</i>			ematory or other place Funeral Bel AIr	Jun	e 27,	Forest	Hill, MD	
Balt	permit. Departi		21. Signature Funeral Service Lice	neee	E	<sup>22. Name and Addre Vans Fun Cremati</sup>	ess of Facility leral Ch on Serv	apel For	Newpor rest Hi	t Dr Z1050	
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, of cor shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a Due to (or a)	consequence of):  EKISCUE  consequence of):  BKTES	15	CARDOU			Approximate Interval Between Onset and Death SWIFKS	
68760,	tificate be executed ig physician and as the burial-transit	edical Ex	resulting in death) Last	Due to (or as a	consequence of):	ENSION	./				
P.O. Box 6	ath cer ttendir or use	Physician/Me	ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome p 1 □Live birth 2 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3	B □Ectopic pregnanc □ Other (specify) □	у		23d. Date of Month	delivery Day Year
	w requires that the de been signed by the s should be detached f	by	Part II. Other significant conditions	contributing to death bu			ren in Part I.	23e. Did toba 1 <b>D</b> Yes		te to the cause of death? ☐ Probably 4 ☐Unknown	
Division or Vital Records,	ding Physician: The law re n. After this certificate has bee funeral director, page 2 sho	Completed						24a. Was an autopsy performe 1□ Yes 2[	prior		
ξ	sician: Th certificate irector, pag	Be c	25. Was case referred to medical examiner?  1 ☐ Yes 2 No	Hospital:	nt 2 ☐ ER/Outpati	ent 3 DOA Oth	ier:	th (Check only one)	0 Flore - 1	Q	
n or	ding Phys	on: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time	of 28c. Injur		ome 5 <b>R</b> Resident 28d. Describe how		эреспу)	
Divisio	Attention of the death of the by the	Certification:	2 Accident investigation 3 Suicide 6 Could not to determine to	e 290 Place of inju	ry - At home, farm, s . <i>(Specify)</i>	M 1 □ street, factory, office	Yes 2□No	28f. Location (Stre City or Town,		r Rural Route Number,	
_	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Medical Ce		hysician: To the best o miner: On the basis of and manner sta	examination and/or						
)	To th withir To th comp	Me	29b. Signature and fittle of certifier)	Doc.V.	Dara	29c. Licens			d. Date signed (M		
(	111		30 Name and address of person who	VALARA	0, M.D.	17/6 HA	KFORD	Rd Su.	105 FAI	-5,2007 USTONHPRYT	
	Sta Registr		31. Date filed (Month, Day, Year)  JUN 2 6 2	37 Registra	r's Signature	sele					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Madeline R. Coffey JUNE 5:20 AM 20, 2007 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death N/A S AINT AGNES HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Hours 1 ☐ M 2 □ XF Months Days 243-60-8435 74 Tennessee Usual Residence of Decedent 10a. State 10c. City, Town or Location 10h. County 10d Inside City Limits 1 XYes 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2309 North Ellamont St 21216 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Director of Medical Records 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Parker O. Coffey Milda Dugger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary L. Griffin/Sister 10014 Reindeer Ct Spring Hill, FL 34608 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 6/23/07 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22 Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd Baltimore, MD 21228 21. Signature of Funeral Service Licensee C. Todd Dring T-XX 23a. Part1. Enter the diseast, or condictations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) PROFOUND SEPSIS 7 unknown source 5 DAYS Due to (or as a consequence of): 2 DAYS SEVERE ACIDOSIS. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to for as a consequence of: INTRAVASCULA 1 DAY. DISSEMINATED Due to (or as a consequence of) COA GULATION IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA 27. Manner of Death
1 Natural
2 □ Accident 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

items 23a or 28a-f show ner must be notified at

and 2 should be filed within 72 hours after death with ealth and Mental Hygiene.

m 27 is marked other than "natural", or items 23a or

f Health aitem 27 is

Pages 1 ?

Medical

the

Baltimore, Maryland 21215-0036

Director MD

Completed by Funeral

Be

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Examiner Physician/Medical þ

Completed

Be

Certification: To

Medical

State

Registrar

4 Homicide

(Check only

AWAIS 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

determined

MD

MASOOD

JUN 2 6 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

filled in by

and physician signed by has this certificate

be executed Box 68760 Ö law requires The To the Hospital or Attence within 24 hours are redeath To the Funeral Director:

۵ Records, Vital or Division Ō

?

DHMH 17 Rev 1/2001

900

32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

P-19508

S CATONS AVE BALTIMORE, MO

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

JUNE, 20, 2007

James Arthur Cassidy 07-04053 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **UNK UNK** 2007 2017 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Time of Death Physician/ Month Day May 28, 2007 1910 hrs Medical Examiner James Arthur Cassidy 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) c. County of Death Cockeysville **Baltimore County** Hunt Valley Towne Centre - 118 Shawan Road If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Director Country)Michigan 373-60-1425 1 X M 2 F 52. JUN 26. 1954 Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items 23a or 28a-f show rother traumatic event, the Medical Examiner must be notified at once. MD N/ABaltimore Funeral Director 10g, Citizen of What Country? 10e, Street and Number 10f Zin Code 3526 Old Frederick Rd 14, Race - American Indian, Black, 11, Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married Married 2 X No Yes 1 Yes 2 X No specify: Specify: White Widowed 4 X Divorced If Yes, Give Year þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 4 Accountant US Postal Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Arthur Cassidy Patricia Hanafin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ₩ E Christine Cassidy/Daughter 10762 Symphony Way Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State or other ant Metro Crematory, Inc | 6/25/07 Baltimore, MD Donation 5 Other Specify 21. Signature of Funeral Service Licensee C. Todd Dring 22. Name and Address of Facility Cremation Society of Maryland, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death Contact shotgun wound of chest Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed and Physician/Medical tending physician a X UNPENDED #Z3a,27,28a-f, perME,g868,6/28/07 TT The law requires that the death certificate be Box 68760. 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Month Year Live birth Day past 12 months? Pregnant at time of death Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown q Unknown 23e. Did tobacco use contribute to the cause of death? o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ξ. 1 Yes 2 No 3 Probably 4 V Unknown Completed Records, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? 2 No ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) director. 25. Was case referred to medical Division of Vital Be examiner? Hospital: 1 ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 this 1 🗸 Yes ဥ No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Natural Yes 2 X No subject shot self Pending death FND 5/28/2007 FND 6:44 pm within 24 hours after death To the Funeral Director: the 2 Accident Investigation filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hunt Valley Towne Centre 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 X Suicide Could not be determined (Specify) Found in wooded areas of mall 118 SHawan Rd. Cockeysville. MD Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. May 29, 2007

Registral

OCMF 2006

State

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32 Registrar's Signatury

M. The Stand

30. Name and address of person who completed cause of death (Item 23a)

6 200

Theodore M. King, Jr., MD.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

		•	For State Registrar	Otato or ma	. y idire	Cer	tificate of	Death		Reg. No	2007	201	111
	Division		1. Decedent's Name (First, Middle, Las	st)					2. Date of De Month	eath Da	y Year	3. Time of	Death
	Physicia /Medic		William J. Clark						June	1	7 2007	19.	pyn
	Examin		4a. Facility Name (If not institution, give	e street and number)				r Location of Death	1		. County of Deat		
			Bel Air Healtha					tir		9	Harfor		
	Funeral Director		5. Social Security Number 6. S 212–18–9169	Sex 7. Age 1	(In yrs. la	st birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Date) 03-03-1	ay, Year)	Co.	hplace (State o untry) yland	r Foreign
	p.		Usual Residence of Decedent		100 City	Town or Loc	nation				-	10d. Inside Ci	ity Limits
	arylar show d at	_	10a. State 10b. County									1 ☐ Yes	1
	e Ma-f s	Director	Maryland Harford		I	allst	T			40- 0	tizen of What Co		1.111
	th with the 23a or 2 st be no	al Dire	10e. Street and Number 2115 Laurel Brook	Rđ			10f. Zip Code 2104	7			S.A.	·	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 【 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:			Vas Decedent of H i Yes, specify Cub ☐ Yes 2X No	lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No to Rican, etc.)	0-	14. Race - Ame Black, White Specify: Whi	e, etc.	
20	72 hc natui lical	sted	15. Decedent's Ed (Specify only highest gra	ducation ade completed)		(Give )	ent's Usual Occup kind of work done	during most of wor	rking	16b. k	Kind of Business/	Industry	
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P	al Hy	Be (	17. Father's Name (First, Middle, Last	)				18. Mother's Nar	, .	e, Maidei	n Surname)		
<u>sa</u>	Ment Ment arked	ဥ	William Clark					Mary Cr					
a	2 sho and Is m		19a. Informant's Name/Relationship (			1		and Number or Re				Zip Code)	
	and ealth n 27		Mary Catherine Cl	ark (Wife)	Logi Bi	l		cook Rd I	Date		ocation - City or	Taura Otata	
Baltimore,	Pages 1 ent of H nt: If itel ry or oth		20a. Method of Disposition  1 🛣 Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specia		Ce	emetery, cren	sition (Name of natory or other pla f Faith		1-2007		ltimore,		and
薑	artm ortar inju	li	21. Signature of Funeral Service Lice		_	22	. Name and Addre	ess of Facility Sc	himunek	Fun	eral Hom	e of Rel	Air
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•	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. Due to (or as a	consequ	ence of):	CO (OA	) C M	CEL	)		Approxima Interval Be Onset and	tween Death
68760,	rificate be executed ng physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	a consequ	ence of):							
O. Box 6	the death certific / the attending p ched for use as i	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome p 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 □ Fetal	death 3	Ectopic pregnanc Other (specify)	у			23d. Date of de Month		Year
Cle ds, P	requires that the een signed by th nould be detache		Part II. Other significant conditions	contributing to death bu	it not resu	Iting in the u	nderlying cause gi	ven in Part I.			use contribute to 2 ☐ No 3 ☐ P		death2 Unknown
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n 6	fer The	ë	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year)	28b. Time of Injury	Wo		28d. Describe	e how inj	ury occurred		
Divisio	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	oe Place of inju	iry - At ho c. <i>(Specif</i> )	me, farm, str	M 1 ceet, factory, office	]Yes 2∐No	28f. Location City or To		and Number or R te)	'ural Route Nui	nber,
/-	Hospita 24 hours Funeral Xely filled	Jical C	29a. Certifier 1 ☐ Certifying P (Check only one), 1 ☐ Medical Exa	thysician: To the best of the basis of and manner sta	examina	wledge, deat tion and/or in	h occurred at the t vestigation, in my	ime, date and plac opinion, death occ	ce, and due to the	e cause e, date a	(s) and manner a and place, and du	s stated. e to the cause	(s)
	To the within 3	Mec	29b. Signature and title of certifier	IIN R	hei	a.A.	29c. Licen	se number		29d. D	ate signed (Mon	th, Day, Year)	
	20		30. Name and address of person who	completed cause of de	eath (Item	23а) (Туре,	Print)	0 1		6	211011		<del></del>
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	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  JUN 2 6 2		ar's Signa	ture	ale)						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death 23ª **Physician** 200 Robert une Rav Crum /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LEN BUZNIE ANNE MEDICAL DACHMATEN ALTIMOR 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 6 Sex **Funeral** Days 1 ▼ M 2 □ F ΚY Director 404-48-1691 10-19-1938 68 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show notified at 1 ☐ Yes 2 X No MD Director Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with pe d ns 23a must b 7860 Twin Ridge Drive 21061 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Items 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status "natural", or Item ledical Examiner n Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: white 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within ... wental Hygiene. 127 is marked other than "-r traumatic eve-" Elementary/Secondary (0-12) College (1-4or 5+) carpenter Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Donna Donald. Crum ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important; If item 27 is any injury or other trauonce. 7860 Twin Ridge Dr., Glen Burnie, MD 21061 Mrs. Mary A. Crum/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Benation 5 ☐ Other (Specify) Stevensville, MD Chesapeake Cremation 6/25/2007 22. Name and Address of Facility Singleton Funeral Home P.A. Funeral Service III Asee 21. Signature 1 Second Ave SW Glen Burnie MD 21061 M01364 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence of: Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician Physician/Medical the IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA ၉ After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 alural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

within 24 hours after deam.

To the Funeral Director: / the

DHMH 17 Rev 1/2001

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

ame and address of person who

drive-

se of death (Nem 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

and manner stated.

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND (ITEM#5.15.17.18.20a-c.22. PFRFH.(871.9/25/07 ਪਲ

		1 - For State Registrar	State of Maryland		artment of Hertificate of L		F	leg. No.		2047.	
Physici	an	Decedent's Name (First, Middle, Last,	)				2. Date of Dea Month	Day	Year	3. Time of Death	
/Medic	al	Roy C. Chambers					June 1			2:28 PM N	
Examin	ier	4a. Facility Name (If not institution, give Prince George's	Medical Center		4b. City, Town, or Chev	erly			ce Ge	orge's	
Funeral Director		<del>223 43 0001</del>	7. Age (In yrs. la.  QM 2 F 69	st birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day Mar 12,	1938	9. Birthp Coun Virgi	lace (State or Foreig try) Lnia	
filed within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland there then "natural", or Items 23s or 28s-1 show ont, it a Medical Example intest be notified at	ector	Usual Residence of Decedent  10a. State 10b. County  MD Prince G		Town or Lo	Heights					0d. Inside City Limits	
th with t	Funeral Director	10e. Street and Number 4105 Will Street			10f. Zip Code	20743		10g. Citizen of V US		try?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Health and Mantai Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 ehow any injury or other traumatic event, Ital Medical Exanting must be notified at once.	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ፟፟፟ Milliproced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cuban 1 ☐ Yes 2ሺ No	panic Origin? (Sp., Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Blac	e - Americok, White,	etc.	
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should Ind Meni	Ţ	Robert Chambers  19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Maılir	ig Address (Street ar	Alice Ander		r, City or Town,	State, Zip	Code)	
Pages 1 and 2 nent of Health a nnt: if Item 27 is iry or other trai		Marilyn Samuels/da		49 Si	lo Lane W	arwick,	NY 10990	)			
Pages 1 nent of P int: If Ite iry or of		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ F  4 □ Donation 5   Other (Specify)	iemovarnom State	ce of Dispo netery, cren Lincol	sition (Name of natory or other place n <b>Cen</b> .	9/22/2	PM7	20c. Location -	12		
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Physician /Medical Examiner		23a Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. ne cause or each line.  Due to (or as a conseque	atic	er the mode of dying	such as cardiac of		est,		Approximate Interval Between Onset and Death	
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Attending Fir death. ector: After by the funer.	Certification;	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day Year)	Injury		es 2 □No					
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To the Hospital or within 24 hours after To the Funeral Director Completely filled in D	edical	29a. Certifier 1. Certifying Physical (Check only one) 2 Medical Examination	sician: To the best of my knowl ner: On the basis of examinatio and manner stated.	edge, death n and/or inv	occurred at the time estigation, in my opi	n, date and place, a nion, death occurr	and due to the cand at the time, d	ause(s) and ma ate and place, a	nner as stand due to	ated. the cause(s)	
To t To tl	Ž	29b. Signature and title of certifier  Force: (a)	lan		29c. License			9d. Date signed			
		3Q. Name and address of person who co		3a) (Type, I	Print) // 82.1	4 885-( Dut	land	61	201	<u>A</u> /	
Sta	te	31. Date filed (Month, Day, Year)	Registrar's Signatur	B A	el ville	ruce	unce	" NOU"	407	TO	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 23, 2007  $P^{M}$ Edward Everett Dravo June 4:05 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Southern Maryland Hospital Prince Georges Clinton If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, MAR 6, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days 1 € M 2 □ F 217-62-8716 53 1954 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2√ No Prince Georges District Heights 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2306 Breton Dr 20747 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Painter Home Improvement 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Avery Dravo, Jr Regina Phipps 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Thomas N. Dravo/Brother 7000 Silver Oak Dr Port Saint Lucie, FL 34952
ce of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc 6/25/07 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee C. Todd Dring Cremation Society of Maryland, Inc. <u> 299 Frederick Rd Baltimore MD 21228</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death IRRHOSIS Immediate Cause (Final OFTHE disease or condition resulting in death) Due to (or as a consequence of): ENCEPHALOPATH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last SEPSIS

Due to (or as a consequence of): E) MONI 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) □Yes 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CASTROINTESTINEAL 1 Yes 2 No 3 Probably 4 Unknown LCOHOL 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autops, performed: 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 TYes 2 TNo 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

**Physician** /Medical Examiner ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

**Examiner** 

Director

Funeral

Completed by

Be

Examiner

Physician/Medical

þ

MD

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No

29a. Certifier (Check only

1 Natural 2 Accident 3 Suicide

6 Could not be determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier mawasout

31. Date filed (Month, Day, Year)

D48158

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6192 OXON HILL READ STESTED OXON HILL MD SISOM OSIA

State Registrar

JUN 2 6 2007

32. Hegistrar's Signature a deliver

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** AVI OOAM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MORE 1 L 1 170 7. Age (In yrs. last birthday) Year Birthplace (State or Foreign Country) If Under 1 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, **Funeral** Months Days Hours 12 M 2□F -18 -742 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 le marked other then "natural", or iteme 23a or 28e-1 ehow or other traumatic event, the Medical Examinar must be notified at 1 ☑Yes 2 ☐ No Be Completed by Funeral Director MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) nd Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HIGRADE permit. Pages 1 and 2 should be file Department of Health and Menial Hy Important: If item 27 is marked othe eny liquy or other traumatic event one. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEKALDINE Baltimore, 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MULTON Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner rsicien and e burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, an Physician/Medical the IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) cate hes been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 1 Yos 2 No 3 Probably 4 Unknown Certification; To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 Yes 2 No 2 No 1 V Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 3□ DOA 2 ER/Outpatient 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 ☐ Hatural 2 ☐ Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours efter death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) to critiying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 260 130041514 hemen M. s 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HEMANIM.D 10 ALMOOR N. Green 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 6 2007

DHMH 17 Rev 1/2001

Registrar

Amend 10e 19b per FH 2893 7/31/09 TT. Ensure All Copies Are Legible. amend items 5,19b 20b per Fh 8893 7-15-09 With Hygiene amend #17 Per FH 2893 7/25/09 Office of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Verna Powell Dickerson Day 22 **Physician** 4:25 AM June 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner University of Maryland Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 □ F 78 Director -2542 14 LA Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 XNo Funeral Director MD Silver Spring Montgomery filed within 72 hours after death with the Hygiene. 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ral", or items 23a or Examiner must be r U.S.A. 20904
Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 3 Morningside, 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Completed by 3 Widowed 4 ☐ Divorced Black 'natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than "natur 15. Decedent's Education (Specify only highest grade completed) Montgomery Co. Dept College (1-4or 5+) Elementary/Secondary (0-12) 12th grade 6yrs Of Social Services 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental 27 is marked of traumatic even Gordon Lucille Remy Benjamin Gordan Powell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 27 Laurie Dickerson-Daughter 3 Morningside 3t. Silver Spring, Md 2090420a. Method of Disposition

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Qonation 5 ☐ Other (Specify) Gate Heaven 6/30/07 Silver Spring, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, 21. Sign Yure of Funeral Service Licensee Baltimore, Md 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Stroke Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): failure Examiner Con gestive heart Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed and Due to (or as a consequence of) physician a s the burial-Box 68760, Physician/Medical the attending IF FEMALE: asn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ tibrillation atrial 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen hypertension 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe coronary artery discase 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Resident Physician June 22 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lynn Pargeon, 22 S. Greene St. Baltimore, MD 21201 Kimberly 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 6 2007 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical not institution, give 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CatonsvIIIe Commons 16 tusting If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthda **Funeral** Months Days Hours 1□M 2X F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location la or 28a-f show t be notified at 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Director mor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Item 27 Is marked other than "natural", or Items 23a other traumatic event, the Medical Examiner must b Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: þ 3 Widowed 4 Divorced act Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. Elementary/Secondary (0-12) College, (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip-Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 Is any Injury or other training once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of Facility

JOSEPH L. RUSS

2222 permit. 21. Signature of Funeral Service Licenses ra 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on which line. Approximate Interval Between Onset and Death Immediale Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner g physician and as the burial-transit that the death certificate be executed Due to (or as a consequence of): Physician/Medical as attending | | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a 9 ☐ Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 The law requires 2 Do 3 Probably 4 Unknown has been sig ge 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page certificate 2 No 1□ Yes 1 ☐ Yes 2 3 10 or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ Did Be 26. Place of Death (Check only one) Other: 2 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 2 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 1 D Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division (Month, Day Year) 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) d manner stated. 29b. Signature a 29d. Date signed (Month, Day, Year) person who complete cause of death (Item 23a) (Type, Print) Catonsuille, MD Avenue

DHMH 17 Rev 1/2001

State

Registrar

2. Registrar's Signature

Year)

200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5:30 AM **Physician** Elila Brown Dorsey 2007 atherine une /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7413 Allmont Boad balti more If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 X F 216-12-0304 Director 100 04-11-1907 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at Baltimore 1 X Yes 2 □ No Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21244 7413 Allmont Hoad Race - American Indian, Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) r than "natural", or iter the Medical Examiner Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: \$ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) alth and Mental Hygiene. 27 Is marked other thar er traumatic event, the M Domestic Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Henry Brown gertrude Mandall-Bias 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

Date

Date

20c. Location - City or Town, State Department of Health Important: If Item 27 any Injury or other troone. Katherine Bacon 20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Park 22. Name and Address of Facility Youghn C. Green Funeral Service 21. Signature of Funeral Service Licensee 8728 Liberty Ad Mandallotam MD 21133 23a. Part1. Entity the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ACZHEIMERS OWN MC ED disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, is along to the mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consecution of): Physician/Medical Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending ph IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown been signed by the should be detached N Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FULL SOUNCEUL 64 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s autopsy performe 1 Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After NIA 1 Natural 5 ☐ Pending investigation ours after death. WILL NIA 1 ☐ Yes 2 ☐ No NIA 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) determined 4 ☐ Homicide N within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 25-0 W. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 HUNZ WESTERNER 21216 WN KICKLAMO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 6 2007

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 24,2007 **Physician** Month 5:05 a<sup>M</sup> CAROL BRADLEY DAVIS JUNE /Medical 4c. County of Death
BALTIMORE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TOWSON GILCHRIST | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | AUG • 8 , 1 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 213-24-0385 1 □ M 🗶 □ F 92 NEW YORK Yrs ,1914 Director Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD BALTIMORE 1 XYes 2 □ No Director 10e. Street and Number 2 OVER RIDGE COURT 10g. Citizen of What Country? 10f. Zip Code or ? 21210 USA items 23a r than "natural", or items 23a the Medical Examiner must I Funeral within 72 hours after death Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify WHITE þ Specify: 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) HOMEMAKER OWN HOME Department of Health and Mental Hygis Important: If item 27 is marked other i any injury or other traumatic event, tt once. 18. Mother's Name (First, Middle, Maiden Surname)
KATHERINE RISING 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental FOLLETT BRADLEY 2 19a. Informant's Name/Relationship (Type. Print) AMANDA MAHONEY da 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daughter 13634 LONGNECKER ROAD GLYNDON, MD 21071 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State BALTIMORE, MD GREEN MOUNT 6/<sub>6</sub> /2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 16924 YORK RD MONKTON, MARYLAND 21111 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OKE **Physician** day /Medical Due to (or a a consequence if): Examiner Sequentially list conditions, if any, leading to immediate caus. Enter Uncorping Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician s the burial Physician/Medical SBS IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed to be detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 performed? certificate ! 1□ Yes 2 No 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) COS မ 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Inpatient After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 5 ☐ Pending investigation 1 Natural Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide TS Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier

5

State

DHMH 17 Rev 1/2001

Registrar

M

Helen



wo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2000au

MD

00051926

Charles St. Balfmano MD

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- For Amend Ite	em 24atepérN	apylan.	d, g868; Cer	tificate of L	<b>a</b> alth and Death	d Menta	l Hygie Reg.	(	" Onios
			1. Decedent's Name (First, Middle,	Last)						e of Death		3. Time of Death
н	Physici /Medio		Ethel Pearl Dig	σq					Mav	22, 2	Day Year 007	1:05 PM M
4	Examir		4a. Facility Name (If not institution,		r)		4b. City, Town, or	Location of De			4c. County of De	ath
			3607 Fairview A	venue			Ва	ltimore				
	Funeral		5. Social Security Number 6		ge (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 H Hours Mi		e of Birth nth, Day, Ye	9. B	irthplace (State or Foreign Country)
	Director		215-24-5936	1□M 2∏F	79	Yrs.	Wichters Days	110013 IVII		1, 19		irginia
	pu .		Usual Residence of Decedent  10a. State 10b. County		10a Cib	. Town or Lo						
	eho.	2	,		Toc. City							10d. Inside City Limits 1√2 Yes 2 ☐ No
	Ne M	Sc	MD			вал	Ltimore			1 -		21
	vith t	Director	10e. Street and Number				10f. Zip Code			10g.	Citizen of What (	Country?
	ath v	a	3607 Fairview				212				USA	
	er de	Funeral	11. Marital Status	12. Was Deceden Armed Forces	?	S. 13. V	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? n, Mexican, Pu	(Specify Yellerto Rican, e	s or No- etc.)	14. Hace - An Black, Wh	nerican Indian, nite, etc.
ဗ္ဗ	rs aft	by F	1 X Never Married 2 Marne 3 Widowed 4 Divorced	d 1 ☐ Yes 2 🔯 If Yes, Give Year or Dates	_	1	I⊡Yes 2⊠ No	Specify:			Specify: b	lack
ᇢ	filed within 72 hours after death with the Maryland Hydione. ther than "natural", or iteme 23a or 28e-f ehow the Madical Exam ar must be mailied at		15. Decedent's			16a Deced	ient's Usual Occupa	ation		165	. Kind of Busines	s/Industry
5	in 72 an" r	Completed	(Specify only highest	grade completed)		(Give	kind of work done of	furing most of w	working	100	. King or Dasinos	a maddily
2	in that	E	Elementary/Secondary (0-12)	College (1-4or	r 5+)		clerk			Soc	rial Seco	urity Adm
<u> </u>	Hyg other	BeC	17. Father's Name (First, Middle, La	est)			O E G E R	18. Mother's N	Name (First,			arrey main
Maryland 21215-0036	ic ev	To B	William Albert	Diggs				Emn	na Lew	is		
37	Should M	-	19a. Informant's Name/Relationship	p (Type, Print)		19b. Mailin	g Address (Street a	and Number or	Rural Route	Number, Ci	ty or Town, State,	Zip Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Heelth and Mental Hygiene if Heelth and Mental Hygiene if them 27 is marked other than "natural", or items 23a or 28e-1 ehow other traumatic event, the Medical Examples invasities notified at		Esther William	s/sister		3607	Fairvie	w Avenu	e Balt	imore	. MD 21	216
ē,	r Hee f Hee item othe		20a. Method of Disposition			ace of Dispo	sition (Name of	I	Date	-	. Location - City of	
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altimore,	permit. Pages Depertment of I Important: If it eny injury or o		21. Signature   Funer   Service Li	# 1		_22	. Name and Addres	s of Facility		<u> </u>		
Ä	Per Per Per Per Per Per Per Per Per Per		Ronald S	, wade win	rector	St	Name and Address ate Anato lltimore,	omy Boar MD 21:	rd 655	W. B	altimore	Street
			26a. Part1. Enter the disease, or coshock, or heart failure. List or	omplications that cause	ed the death					atory arrest,		Approximate
	Discontinue		shock or heart failure. List or Immediate Cause (Final									Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a Ac	· vle	ience of):	-dial	in berch	760			1 400-
	Examiner						1	disu				5
		ē	Secuentially list conditions if any, leading to immediate cause. Enter Underlying	b. Due to (or a	s a consequ		enleng	01941	086			3 years
	uted d ansit	Ĕ	cause. Enter Underlying Cause (Disease or injury that initiated events									
<u>,</u>	exect n and ial-tra	Examin	resulting in death) Last	Due to (or a	s a consequ	ience of):						
8760,	icate be executed physicien and s the burial-transit	dicai		d ===								
89	ificat g phy as the	00 1										
ŏ	The law requires that the death certific sie has been signed by the atlending p page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom							23d. Date of d	elivery
P.O. Box	d for	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	1□Live birth 4□Pregnant a			Ectopic pregnancy   Other (specify)				Month	Day Year
O.	t the oy the ache	hys	9 □ Unknown	9□ Unknown								
	w requires that the dibean signed by the should be detached	by P	Part II. Other significant condition	s contributing to death	but not resu	ıltıng in the ur	nderlying cause give	en in Part I.	236	e. Did tobac	co use contribute	to the cause of death?
ğ	quire on sig old b		Emply sev	40					_	1 🗆 Yes	2 No 3 1	Probably 4 Unknown
ပ္ပ	law re as bee 2 sho	olet	, .						248	a. Was an	24b. Were	autopsy findings available completion of cause of
Vital Records,	The la	Completed							-	autopsy performed	l?   death?	7
Ta Ta		au I	25. Was case referred to medical	1				26. Place of D		Yes 2	No 1 Ye	es 2 No
>	Physician: r this certifici ral director.	To B	examiner? 1 ☐ Yes 2.2 No	Hospital:	ient 2 🗆 I	ER/Outpatien	Othe	AC			e 6 □Other (Sp	naciful
Division of	a Phy erthi eral (	L.	27. Manner of Death	28a. Date of Inj	jury	28b. Time of	28c. Injury Work			.>	njury occurred	ocity)
0	ath. I. Ath	atio	Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, D	ay rear)	Injury		? Yes 2 ☐ No				
N N	Atte	HICE	3 Suicide 6 Could no 4 Homicide determin	ed 286. Place of in	njury - At ho	me, farm, stre	eet, factory, office					Rural Route Number,
ā	s efte	Certification;	4   Homicide	building, e	etc." (Specify	')			City	or Town, S.	rate)	
	hour hour uners ly fills		29a. Certifier Certifying	Physician: To the bes	t of my know	wledge, death	occurred at the tim	e, date and pla	ace, and due	to the cause	e(s) and manner a	as stated.
	To the Hospital or Attending Physician: within 24 hours elfer deals. To the Funerel Director: After this certific completely filled in by the funeral director.	edicai	(Check only 2 Medical Ex	kaminer: On the basis and manner s	of examinat stated.	ion and/or inv	estigation, in my of	oinion, death oc	courred at the	e time, date	and place, and di	ue to the cause(s)
	To t With To t	Σ	29b. Signature and title of certifier	0//		)	29c. License	number		29d.	Date signed (Moi	nth, Day, Year)
)			PU D	-1/011	111		043	381			6-13.07	_
	1		30. Name and address of person w									h.
	0		Daniel R.	Howard 32. Regis	17	14 E	ctus 1	Merce	Bl	tinone	19	21217
	Sta	_	31. Date filed (Month, Day, Year)	32. Regis	trar's Signat	lura	4					
	Registr	ar	JUN 2 6 2007	Classes 1	J. R.	DEALLS						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend #5, perInf. 6869, 7/2/07 TT Certificate of Death

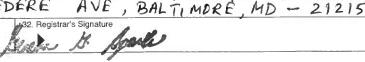
Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 22 DUBICK JUNE 2007 2:40 **ISIDORE** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner JEWISH CONVALESCENT CENTER BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 18-2434 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F 86 07/09/1920 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural"; or Items 23a or 28a-f show any liny or other traumatic event, the Medical Examiner must he natural once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State ¹**y**⊡Yes 2 □ No Director BALTIMORE MD N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21209 2216 ARDEN ROAD Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, et 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 ò 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PAPER SALES 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SCHMUCKLER ٩ KATE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2216 ARDEN ROAD - BALTIMORE, MD 21209 IDA DUBICK / WIFE 20b. Place of Disposition (Name of SHAARET TFILOH CONG. Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 06/24/2007 WOODLAWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final gementia Physician Vascular 6 months disease or condition resulting in death) /Medical Examiner Cardiovascular disease merosclerotion > 6 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine as the burial-tran and Due to (or as a consequence of): attending physician for use as the buria Division or Vital Records, P.O. Box 68760 The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension, coronary artery disease 1 Yes 2 No 3 Probably 4 Unknown Completed fibrillation, Hyperlipidemia 24a. Was an autopsy performed? 1□ Yes 2M No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 completely filled in by the funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the I within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0053928 06/22/07

State Registrar 31. Date filed (Month, Day, Year)

W. BELVEDERE



AVE

30. Name and address of person the completed cause of death (Item 23a) (Type, Print) SURALYA BEWYM, MD

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Year

11:59AM

Birthplace (State or Foreign Country)

Day

5601 Loch Raven Blod. Battimere, MD 21339

Year

10d. Inside City Limits

1 ☐ Yes 2X No

 Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** Alice J. DeSantis 1200-June 21 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Baltimore 8. Date of Birth (Month, Day, Year)
Sept. 28,1921 Maryland If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 5-Social Security Number 6. Sex **Funeral** Months Days 1□M 24 F Hours 213-14-3123 85 Director Usual Residence of Decedent 10c, City, Town or Location the Maryland 10a State 10b. County at MD Baltimore Parkville r 28a-f sh notified a 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ral", or items 23a or Examiner must be r death with 7111 Old Harford Road 21234 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after of neath and Mental Hygiene. and the filed share in the share and the than "natural", or liter and the transmitted other than "natural", or liter traumatte event, the Medical Examiner ury or other traumatte event, the Medical Examiner 1 ☐ Yes 2 **∑**No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No SpecifyWhite 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Dry Cleaner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Stankowski Veronica Litwinski ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Felinus DeSantis, OFM CONV-SON 1920 Skyview Drive Lithia Springs, GA 30122 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Stanislaus 6/25/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Miller-Dippel Funeral Home 21. Signature of Funeral Service Licensee 6415 Belair Road Baltimore, MD 21206 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ust only one cause on each line. 23a. Part1. Enter the disease shock, o heart failure. Immediate Cause (Final Physician frobable disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Month in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Nnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one examine. 1 ☐ Yes 2 Deto Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🔲 Inpatient 2 ER/Outpatient 3 □ DOA ဥ 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 1 1 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide in by determined 4 Homicide To the Hospital within 24 hours at To the Funeral C ectifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier N0029240 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

2007

DHMH 17 Rev 1/2001

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, D. O.

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 8:55 PM 700T Elliott 18 June Joyce /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner University of Maryland Medical Center Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 0 9 - 2 9 - 1 9 6 4 9. Birthplace (State or Foreign . Social Security Number 6. Sex **Funeral** 1 □ M 2 🕸 MaryTand 213-88-4663 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner must be nother than once. 10c. City, Town or Location Baltimore 10d. Inside City Limits 10a. State MD 1X Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 1055496 Hillburn Ave. 21214 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Mamied Black 1 ☐ Yes Z No Specify: Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Private Elementary/Secondary (0-12) College (1-4or 5+) Certified Medical Asst. 18. Mother's Name (First, Middle, Maiden Syrname) Joyce Ann Williams 17. Father's Name (First, Middle, Last)
Radcliff Elliott Be မ 19a. Informant's Name/Relationship (Type Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Joyce Elliott-Tillman/Mother 5416 Hillburn Ave., Baltimore, MD 21214 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill 20a. Method of Disposition
1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State 6-26-07 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of FacilityRonald Taylor II FH 21. Signature of Funeral Service Licens 108 W. North Ave., Baltimore, MD 21201 ona 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pulmonary Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that the death certificate be executed that initiated events resulting in death) Last physician and s the burial-tran Due to (or as a consequence of): Physician/Medical the as attending | | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 9□Unknown Month Day Year 5 Other (specify) 1 ☐ Yes 2 No Division or Vital Records, P.O. the 9 ☐ Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No ို After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Certification: 5 Pending investigation 1 Natural 1 Tes 2 No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura P19729 June 18, 2007 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Battimore, MD 22 South Greene Street

DHMH 17 Rev 1/2001

State

Registrar

Cheryl Hepp,

31. Date filed (Month, Day, Year)

JUN 2 6 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 12:19 a June 23. 2007 /Medical John J. Evdelloth 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, Ye Baltimore Towson Gilchrist Hospice Center 9. Birthplace (State or Foreign Country) Maryland If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number Year) Days Hours Months 1 M 2 □ F Yrs. 79 212-24-9019 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 X No Colgate MD Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21224 USA 7905 Eastdale Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White δ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Arundel Corp. welder 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katherine Schmidt George Eydelloth ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7905 Eastdale Road Baltimore, MD 21224 Betty Eydelloth- Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 6/26/07 Baltimore, Maryland Oaklawn Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Charles S. Zeiler & Son 21. Signature of Funeral Service Licensee 6224 Eastern Avenue Baltimore, MD 21224 Part . Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final eas s Dementio disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Was a. autopsy performed? 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: HOSPILE 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Qther (Specify) 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No

/Medical Examiner be executed burial-transit and Box 68760, attending physician for use as the buria The law requires that the death certificate ed by the a Division or Vital Records, P.O. been signed by should be detac page 2 certificate Hospital or Attending Physician: director, this funeral After after death.

I Director: Ald in by the fu To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b

**Funeral** 

Director

"natural", or items 23a or 28a-f show idical Examiner must be notified at

the Medical

than

ages 1 and 2 should be fill out of Health and Mental Hit: If item 27 is marked oth y or other traumatic evening.

permit. Page Department o Important: If any injury or

**Physician** 

Pages 1

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

10 Registrar

Gordon M. 31. Date filed (Month, Day, Year) JUN 2 2007 6

29b. Signature, and title of certifier

6 ☐ Could not be

determined

2 Accident

3 ☐ Suicide

29a. Certifier

Medical

State

4 Homicide

,6565 N

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

MO

Charles St Baltonore

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

00051926

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

200

21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 3 Time of Death Decedent's Name (First, Middle, Last) Year **Physician** 7:55AM harlotte 2007 Flowers Do 20 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Keswick Nursing Baltmore Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12 20 1916 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 XF 90 220.12.2941 Yrs Director Usual Residence of Decedent deeth with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State worde. r then "nature!", or items 23a or 28a-f ehov the Medical Examiner must be notified at Baltimore 1 Yes 2 No MD Be Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21218 Bartlett tvenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Inhorbant: if Item 27 ie marked other then "naturel; or Item eny injury or other traumatic event, the Mudical Examinations. 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Education 12th grade leacher tyears 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Warren Andrews Funnie Andrews ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5202 Dry break Court Baltmore MD 2/206

20b. Place of Disposition (Narthe of cometery, crematory of other place)

Mt. Calvary Cemetary 06/23/07 Glen Burnie, MD 20bert Flowers 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2 Jame and Address Facility Voughn C. Greene Funeral Souce 21. Signature of Funeral Service Licensee York Road Baltimore MD 21212 m01363 4905 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hysician DEMENTIA nkown END STAGE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in modulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examiner attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown HYPEIZTENSION Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28b. Time of 28a. Date of Injury (Month, Day Year) Certification: After 5 Pending investigation after death. Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide within 24 hours a To the Funerel E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MO 00059056 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2/2/1 SALUTA MD 4075 BALT MD 700 DALJEET ST WEST 32 Registrar's Signature 26 State

DHMH 17 Rev 1/2001

Registrar

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2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2007 3:30 June Geneva Lorraine Fryfogle /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Arnold 1277 Ritchie Hwy, Unit 192 8. Date of Birth (Month, Day, AUG 31, Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 5. Social Security Number **Funeral** Days 1 ☐ M 2 😿 F 89 1917 Maryland 215-10-3510 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 No Anne Arundel Arnold MDDirecto 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a or: any Injury or other traumatic event, the Medical Examiner must be n USA 21012 1277 Ritchie Hwy, Unit 192 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Specify: White 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Baltimore, Maryland 21215-0036 þ 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Apartment Complex Rental Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth A. Schmidt Alexander Benderoth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1384 Almond Dr Annapolis, MD 21409 William Bevans/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 6/25/07 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Cremation Society of Maryland, 299 Frederick Rd Baltimore,MD 21. Signature of Funeral Service Licensee C. Todd Dring lock 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** (or as a consequen of): /Medical Examiner orenany Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and be to the Funeral Director after this certificate has been signed by the attending physician and be the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FFMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performs 1∐ Yes 2 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 10 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 1 ☑ Natural 2 ☐ Accident Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

Medical

29a. Certifier

30. Name and

29b. Signature and title of certifier

,alle filed (Month, Day, Year)

JUN 26

29c. License number

colour Dr. Amondis, 40

29d. Date signed (Month. Dav. Year)

and manner stated.

address of person who completed cause of death (Item 23a) (Type, Print)

07-04810

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Richard Wayne Gordon 1- For State	State of Marylan	d / Department of Certificate or		d Mental Hy	/giene Reg. I	No.	17 11.04.8
Physician/ 1. Decedent's Name (First,	, Middle,Last)				Date of Death     Month Da		3. Time of Death
Medical Examiner Richard Way				Land of Dark	June 24, 200	4c. County of Deat	2118 hrs
4a. Facility Name (if not ins	stitution, give street and numb	per)	4b. City, Town, or Lansdowne			Baltimore Co	
Funeral 5. Social Security Number	6. Sex 7.	Age (In yrs. last birthday)	If Under 1 Year		_	MM/DD/YYYY) 9. Bi Forei	rthplace (State or
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29b. Signature and title of	and manner sta	ated.	29c. Licen	ise number		29d. Date signed (f	Month, Day, Year)
I XIV	AUX /L	1	0.0	.M.E.		June 25, 2007	
8	person who completed cause ID. Assistant Medica		enn Street, Ba	Itimore, MD 2	1201		
Susan Hogan M  State 31. Date filed (Month, Da	y, Year) 32 Rec	gistrar's Signature	W Street, Ba				
Registrar	2 2087 Sta	we A Ago					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) a3 Year Physician 22:22 June ner 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hockins Bayview Medical Center
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Bo Himore or 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** 1**№** M 2□ F Days Hours Min 216-68-5807 MD Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County a 14 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 Ter 2 □ No Funeral Director MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number lorner USA permit. Pages 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muones. 14. Bace - American Indian 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be -elln Rena Rankin 2 John Hanus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Richmond, VA 23221 ate 20c. Location - City or Town, State 3301 West Grace St. FFany Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 Defemation 3 ☐Removal from State netro Crenatery 6-30-07 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Fine ral Service Lio 22. Name and Address / Facility 1232 Midvellay Dr. Jessup, PA 18434 Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part shock Immedia\* Cause (Final disease or condition resulting in death) Gastraintestinal Physician /Medical Due to (or as a consequence of): Examiner Esophagial
Due to (or as a consequence of): Se quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed Alcohol Abuse burial-trar Due to (or as a consequence of): physician s the burial-P.O. Box 68760, Physician/Medical as attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown g □ t Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pivision or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an is certificate has director, page 2 s autopsy performe 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 27. Manger of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident neral Director: / 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion, death accurred. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) Medical Doctor June 26, 2007

Registrar

State

Yolanda

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

4940 EASTERN AVENUE, BALTIMORE, MD. 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2007 **Physician** June 7:05 a M Grace Belle Garland /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1731 Manchester Rd. Carroll Westminster | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 8, 1909 Birthplace (State or Foreign Country) . Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1 ☐ M 2 🛛 F 97 North Carolina Director 219-12-1013 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 21 No Director Carroll Westminster Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1731 Manchester Rd. 21157 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black. White, etc. I □ Yes 2 □ No f Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: Completed by 3√ Widowed 4 Divorced White Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assembly Line Black & Decker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Tipton Blanche Slagle 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myra Loray Hawn - daughter 1731 21157 Manchester Rd. Westminster, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of F Important: If Ite any Injury or ot Finksburg, Md. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) Evergreen Mem. Gardens June 28,2007 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Eckhardt Funeral Chapel P.A. heles Hall 21102 3296 Charmil Dr. Manchester, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on eacy ine. Approximate Interval Between Onset and Death Immediate Cause (Final 1100 Physician resulting in death) /Medical **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transi and Due to (or as a consequence of): attending physician Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? ō Month 5 Other (specify) director, page 2 should be detached 9 Unknown ρ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA ဥ completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 1 Natural 28c. Injury at Work? 28d. Describe how injury occurred : After Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 the Hospital or Attending Physician: death. after death within 24 hours a

Baltimore, Maryland 21215-0036

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Ter: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and panner stated. 2 ☐ Medical Exa ature and the of certifier 29b. Sign State

determined

3 ☐ Suicide

4 Homicide

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

31. Date filed (Month, Day,

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

07-04718

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Girard Scott Hall State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month Day June 20, 2007 Year 1030 hrs **Medical Examiner** Hall. Girard Scott 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Parkville **Baltimore County** 46 Astro Court 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Numbe If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday **Funeral** Days Months Hours Min Director Country) MD FEB 8 1985 215-08-9632 22 1 X M 2 Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 X Yes 2 No or 28a-f show N/A Baltimore must be notified at once. MD Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country 205 S. Monroe Street USA 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. or items Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. after death 1 X Never Married Marrie 2 X No Yes ment of Health and Mental Hygiene.
tan: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner Widowed Divorced If Yes, Give Year Yes 2 X No specify: Specify: **Black** þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 72 hours Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Janitor Horse Racing 18.Mother's Name (First, Middle, Malden Surname) 17, Father's Name (First, Middle, Last) Be Girard Scott Hall, Sr. Rhonda Randall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD Girard S. Hall, Sr. - father Baltimore, Monroe Street, MD20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State Department of Inc. 6/23/2007 Metro Crematory, Baltimore, Donation 5 Other Specify. 21. Signature of Funeral Service Licensee Steven H 22. Name and Address of Facility Cremation Society of Maryland, Inc. Williams 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical Death a Multiple Gunshot Wounds and Sharp Force Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical signed by the attending physician be detached for use as the burial UNPENDED AMENDED Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Day Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ⋧ Yes 2 ✔ No 3 Probably 4 Unknown Completed has been si 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? certificate Yes 2 1 🗸 Yes No To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) funeral director, Division of Vital Be Other<sub>4</sub> Residence 6 V Other: Scene ER/Outpatient 3 DOA Nursing Home 5 Inpatient 2 this 1 V Yes 28a. Date of Injury (Month, Day,Year) FOUND: 28c. Injury at Work? After 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification Subject shot, stabbed and cut FOUND: Natural Yes 2 V No within 24 hours after death.

To the Funeral Director: 5 Pending To the Funeral Director: completely filled in by the Jun 20, 2007 1012 hrs Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be or Town, State) 46 Astro Court, Parkville, MD (Specify) Townhouse / Rowhouse 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 21, 2007 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner

State Registra

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Amend #1 Per PHy G868 6/26/07 Celhificate of Death Myanna Jacayla Holmes . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death acayla" Month 12:00 P M **Physician** 18 2007 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Battimore universit If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Ukn 1 □ M 2 🛛 F 06 Director 2 16 07 MD Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show be notified at 10a. State 10b. County M Yes 2 □ No Baltimore NA Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. ral", or items 23a Examiner must b 21244 8011 Woodgate Ct. # A Pages 1 and 2 should be filled within 72 hours after death nent of Health and Mental Hygiene. Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√ No If Yes, Give 1 Never Married 2 Married 21215-0036 1 ☐ Yes 🎾 No Specify Specify: Black \$ 3 Widowed 4 Divorced Yeer or Dates: "natural", er than "natur the Medical I Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A N/A N/A If item 27 is marked other or other traumatic event, til Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Antoine Terrell Holmes Anna Katrina Pridgeon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8011 Woodgate Ct. #A, Baltimore, Md 21244 Anna K. Pridgeon-Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 Cremation 3 Removal from State Department of Important: If any Injury or once. Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 6/28/07 21. Sign Juny of Funeral Service Licenses March F/H West 4300 Wabash Ave, Baltimore, Md 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healthfailure. List only one cause on each line. 21215 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cardiones **Physician** /Medical I hypovolemic shock 24 hours Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) remopertaneum, I wer hernatama, NH24 Examine The law requires that the death certificate be executed Due to (or es a consequence of): and physician as Box 68760. Physician/Medical the attending p IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 \sum No certificate Yes 25. Was case referred to medical Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records, P.O. To the Hospital or Attending Physician: within 24 hours after deaft To the Funeral Director completely filled in by the

State

Medical

29b. Signature and title of certifier

D0061011

29d. Date signed (Month, Day, Year) June 18, 2007

completed cause of death (Item 23a) of manyland medical cent of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

31. Date filed (Month, Day, Year)

(Check only one)

> JUN 2 6 2007

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	State of Maryland / Department of Health and Mental Hygiene  State per In, 8868,06/26/0/dbb Certificate of Death  Reg. No.
	* Physicia	an	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year 3. 35 PM
	/Medic Examin		4c. County of Death  As. Facility Name (If not institution, give street and number)  As. Facility Name (If not institution, give street and number)  Baltimore
Maria	Funeral Director		5. Social Security Number 6. Sex 1 Months Days Hours Min. 6. Sex 1 Months Days Hours Min. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Country) MD 9. Birthplace (State or Foreign Country) MD
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	Mary I eho	ţo	MD Baltimore Raltimore
	with the	I Direc	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA USA
980	d within 72 hours after death with the Maryland jiene. I than "neturel", or Items 23s or 28s-f ehow The Medical Evanit wit must to incitified at	by Fur	11. Marital Status  1
21215-0036	I within 72 jene. r than "ne the Wedic	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12th  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Baltimore City Public Schools
and	should be filed nd Mental Hygi marked other imatic event, I	o Be	17. Father's Name (First, Middle, Last)  William Parrish  18. Mother's Name (First, Middle, Maiden Sumame)  Anna Parrish
Maryland	0 6 60	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  3911 Dorchester Rd., Baltimore, MD 21207
altimore, I			Joan Saunders/Daughter  20a. Method of Disposition  1 Runial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Maryland National  20c. Location - City or Town, State  06/20/2007  Laurel, MD
Baltiı	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Vaughn C. Greene Funeral Service  8728 Liberty Rd., Randallstown, MD 21133
8760,	/Medical Examiner buy sician and sician and sician and sician and sician site of the private for the private f	sal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Onset and Death  Coretovasco at the coldect  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):
.O. Box 68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown  23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 5 ☐ Other (specify)
<u>α</u>	es that tigned by	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
Records,	eicien: The law require certificate has been sii lirector, page 2 should b	Completed	Hyperteisure Arterioeclastic Cotracy Varcular Otroce 1 yes 2 No 3 Probably 4 Bothknown  Declartes  24a. Was an autopsy performed? 1 yes 2 Dro 1 yes 2 Dro 1 yes 2 Dro 1 yes 2 Dro
Vital	yelcien: ) is certifica director, p	BeC	25. Was case referred to medical 26. Place of Death (Check only one)
of V		P	1 Yes 2 Nursing Home 5 Residence 6 Other (Specify)
ion (	ding After fune	atlon	1 ∰Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No
Division	el or Attends safter death	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospitel or Attens within 24 hours affer deall To the Funeral Directors completely filled in by the	edical C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To the within 2. To the complet	Me	29b. Signature and title of certifies 29d. Date signed (Month, Day, Year)
			Mr. real January D1966) 06.26.3007
	10)		20. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Viillaci (Resource) 7 310 Pitchise Hybraces 1508 Glen Bornier, Macybrid 21dg
	St Regist	ate rar	31. Date filed (Month, Day, Year)  32. Registrar's Signature  JUN 2 6 2007  August & Apple

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State o	f Maryla		artment of I rtificate of		and Me		giene Reg. No.		2 1.93
	Dhysisi		Decedent's Name (F)	First, Middle, La	st)						2. Date of Dea	ath	Year	3. Time of Death
	Physici /Medio		Vera W. Hud								June 20			4:40 PM M
	Examin	er	4a. Facility Name (If not <b>5211 Andov</b>		e street and nu	mber)		4b. City, Town, o	Chevy	Chas	e		ounty of Dead	
	Funeral Director		5. Social Security Number 511-42-4444		Sex 1 □ M 2 S F	7. Age (In yr 70	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 10/30/	1936	9. Biri Pal	thplace (State or Foreign ountry) <b>estine</b>
	/land low at		Usual Residence of Dec 10a. State 10	cedent b. County		10c. (	City, Town or Lo	ocation						10d. Inside City Limits
	a-f sh	cto	MD N	Montgom	ery	Ch	evy Cha	ase						1 □ Yes 2 No
	vith the	Director	10e. Street and Number					10f. Zip Code 20815-				-	n of What Co ed Sta	•
	eath v	Funeral	5211 Andove	er ka.	12 Was Dec	edent Ever in	US 13	Was Decedent of I		nin? (Snec	cify Yes or No-		. Race - Ame	
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, them "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 □ Never Married 3 □ Widowed 4 □		Armed Fo 1 ☐ Yes If Yes, Gi Year or D	orces? 2)K) No ve		If Yes, specify Cub 1 ☐ Yes 2 【 No	oan, Mexicar	i, Puerto F	Rican, etc.)		Black, Whit pec <i>ify:</i> <b>Wh i</b>	
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	Physician /Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  Metas to final cause (Final disease or condition)											Approximate Interval Between Onset and Death	
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5	Sta Registi		31. Date filed (Month, L		32 F	Renistrar's Sin								

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 Month June 22, 0547 Joanne Marie Hooper 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Gilchrist Hospice Center Baltimore Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, Year) | 0 5 • 2 1 • 1 9 5 3 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 216.48.4660 1 □ M 2 X F 54 MD Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 □Yes 2 No Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 302 E.Joppa Road Apt. 1001 U.S.A. 21286 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Lee Hooper Margaret Mary Dollard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas J. Hooper/Brother 1220 Bank St. Unit 406, Balto., MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Chesapeake Crem. 06.23.07 | Beltsville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Cremation And Funeral Balto 21. Signature of Funeral Service Licens Alternatives 8717 Green Pastures Dr. MD 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on pach ine. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

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2

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

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The law requires that the death certificate be executed the Hospital or Attending Physician: within 24 hours after death To the Funeral Director:

Division or Vital Records, P.O. Box 68760,

Registrar

Part II. Other significant conditions co	ntributing to death but not resu	ulting in the underlying	g cause given in Part I.		tobacco use contribute to the cause of death?			
				1 🗆	Yes 2 No 3 Probably 4 Unknown			
25. Was case referred to medical			26. Place of Dea	th (Check only o	one) : 1			
examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ I	DOA Other: 4 Nursing H	ome 5 🗆 Resi	idence 6 Dother (Specify) Hospica			
27. Manner of Death  1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injury occurred			
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At ho building, etc. (Specify	ome, farm, street, factory)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one)  29a. Certifier (Check only one)  1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day,								
29b. Signature and title of confiler	7 1 2	2	29c. License number		29d. Date signed (Month, Day, Year)			

200

N. Chr

29d. Date signed (Month, Day, Year)

June 22, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701 6 BMC 32. Registrar's Signature

31. Date filed (Month, Day, Year) 26

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death William Charles Harris Month Year 7:40 7007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital N/A Baltimore 8. Date of Birth (Month, Day, Year) NOV. 12,1948 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1⊠M 2□F Months Days Hours 213-52-7458 Yrs. 58 Ohio Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Yes 2□No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4201 Falls Road Apt 3 21211 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2K No Specify: White 3 Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation

Photographer

4201 Falls Road,

(Give kind of work done during most of working life. DO NOT use retired)

PM

16b. Kind of Business/Industry

Art Industry

June 23,2007

Baltimore, Maryland 21211

Reid

18. Mother's Name (First, Middle, Maiden Surname)

Theresa Allien

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Apt 3,

**Physician** /Medical

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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10a. State

Elementary/Secondary (0-12)

Marsha Luria

12

Earl Cranston Harris

19a. Informant's Name/Relationship (Type. Print)

17. Father's Name (First, Middle, Last)

College (1-4or 5+)

Wife

5+

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LOUIS

31. Date filed (Month, Day, Year)

**Funeral** 

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran physician þ certificate this After

Division or Vital Records, P.O. Box 68760

in 24 hours area the Funeral Director; Af within 2

> State Registrar

DHMH 17 Rev 1/2001

Union Memorial Hospital

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diw dish	23a or 28a-f show	al Dir	10e. Street and Nur 19506 M	mber IDDLETO	WN RD.			101.	Zip Code 2105	53			tizen of V SA	Vhet Coun	itry?	
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ang.	Physici /Medi		Peter			tone				June	14		207	6 15 M
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	Funeral		5. Social Security Number 6. S 220–16–8798	M 2□F	je (In yrs. last b. 82		nths Days	Hours	Min.	8. Date of Bir (Month, Da May 19	y. Year)	25	Cou	place (State or Foreign ntry) unk
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	23a c	alD	P.O. Box 6314					212	230			USA		
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Baltimore,	그런런즘 .		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ronald S. Wade Director State Anatomy Board 655 W. Baltimore S											
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Division	I or Attendi after death. Director: A I in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	280. Place of In	jury - At home, to. (Specify)	farm, street, fa	actory, office			28f. Location (			or Run	al Route Number,
	rs aft	Cer												
	to the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer		(Check only 2 Medical Exac	nysician: To the best miner: On the basis of	of examination a	ge, death occi	urred at the tin ation, in my o	ne, date a pinion, de	and place, eath occur	and due to the	cause(s	and man	ner as s	stated. to the cause(s)
	within 24	Medical	one)	and manner st	ated.		29c. Licens							
	Twit Co.		29b. Signature and title of certifier	01						-				Dey, Year)
			Ibironice				Res	- 0	00		ار	ine 1	4 .	200 T
			30. Name and address of person who					( 00 - 1	la Hala	laica SLIA	ot r	) (lab a r	0.0	M
	- CA	ate	Thironice Oduyeb 31. Date filed (Month, Day, Year)	2. Registr	rar's Signature	KING HO	>pital,	600 N	DV IVI V	wite she	~1, 5	Dalning	ve,	Maryland a 4
	Regist	ate rar	JUN 2 6 200	7 190000	. 1	doorte	P							

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep 1 - State of Maryland / Dep 1 - State of Maryland / Dep 25 per verb., g	artment of Health and Mental H 106/26/07/Jhb Hillicate of Death	ygiene 2007 20453
	Physici		1. Decedent's Name (First, Middle, Last)  KUDENT HILLS	2. Date of Month	Death Day Year 3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give streen and number) Future (are ) ruinsten	4b. City, Towntor Location of Death	MD 4c. County of Death
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 214-44-5682 1 M 2 F 60 Yrs.	If Under 1 Year   If Under 24 Hrs.   8. Date of 1 Months   Days   Hours   Min.   Sept	Birth Pay, Year) 9. Birthplace (State or Foreign Country) 4, 1946
	e Maryland	tor	Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or L		10d. Inside City Limits ttv Yes 2 ☐ No
	with the 3a or 284 If be not	i Direc	10e. Street and Number 629 Plymouth Road	10f. Zip Code 21229	10g. Citizen of What Country?  USA
920	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or Items 23a or 28a-f ehow other traumatic event, the Medical Exercitiest must be invitibled at	by Funeral Director		Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 No Specify:	
21215-0036	I within 72 ho iene. r than "natur itte Medical	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry unk
Maryland 2	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Ma	To Be C	17. Father's Name (First, Middle, Last)	unk 18. Mother's Name (First, Midd	dle, Maiden Sumame) unk
	nd 2 sho lith and h 27 is ma r trauma			ng Address (Street and Number or Rural Route Num <b>3.</b> Athol Avenue Baltimor	A CONTRACT OF THE PARTY OF THE
Baltimore,	Page nent c ant: # ury or		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  1 Donation 5 Definer (Specify) in state	osition (Name of Date matory or other place)	20c. Location - City or Town, State
Ball	permit. Pag Department Important:: any injury c		Ronald S. Wide, Director S. B.	2. Name and Address of Facility tate Anatomy Board 655 W altimore, MD 21201	
	Frnysician /Medical Examiner	Examiner	23a. Pant. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ter the mode of dying, such as cardiac or respiratory  The true five all way	Approximate Interval Between Onset and Death O
Box 68760,	ate be ex hysician the buria	dical	Due to form as a consequence of):  d.  IF FEMALE: 23b. Was decedent pregnant	)	23d. Date of delivery
P.O. B	that the death ed by the atte detached for	by Physician/Me	in the past 12 months?	□Ectopic pregnancy □ Other (specify)	Month Day Year
	w requires that the death certific been signed by the attending p should be detached for use as	ted by F	Part II. Other significant conditions contributing to death but not resulting in the		d tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown
Division of Vital Records,	The law ate has t page 2 s	Completed		24a. W au pe 1 🗆 Yes	prior to completion of cause of death?
f Vita	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death (Check online 1 3 DOA Other: 4 Nursing Home 5 Re	fy one) , asidence 6 □Other (Specify)
ion o	Jing After fune	ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year) Injury	of 28c. Injury at Work?  M 1 □ Yes 2 □ No	be how injury occurred
Divis	al or Atte s after de al Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)		n (Street and Number or Rural Route Number, Town, State)
	To the Hospital or Attending Ph within 24 hours atter death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or is and manner stated.	nvestigation, in my opinion, death occurred at the tim	ne, date and place, and due to the cause(s)
*	To the within 2 To the complete	×	29b. Signature and title of certifier  Implying Al North	29c. License number  D15503	June 03207
			30. Name and address of person who completed cause of death (Item 23a) (Type AMA TUM M ALAM), Sci	Bolphis stred, E	Balto MD 2 218
	Sta Regista		31. Date filed (Month, Day, Year)  32. Registrar's Signature  31. Date filed (Month, Day, Year)	V	,

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

JIICIGOTI II. IIIIII		1-For State Registrar  1-For State  Certificate of Death		No.				
Physici	an/	Decedent's Name (First, Middle,Last)	2. Date of Death		3. Time of Death			
Medical Exam	iner	Sheldon Henderson Inniss, Sr.	June 23, 20		0237 hrs			
1		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death University Hospital  Baltimore		4c. County of Death				
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	. 8. Date of Birth	(MM/DD/YYYY) 9. Bir	hplace (State or			
Director		1975 Foreig	n untry)Barbados					
any	Funeral Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits			
faryland 28a-f show I at ouce.		MD Baltimore Essex	12.0		1 Yes 2 No			
3, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leafth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.		951 Ashbridge Drive 10f. Zip Code 21221	100	g. Citizen of What Cour USA	ntry?			
death witl r items 2 nust be n		11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto		. White, etc.	can Indian, Black,			
after	by F	3 Wildowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:			ick			
hours'a: "natural"		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of v during most of working life. DO NOT use retired to the property of the control of		16b. Kind of Business/I	ndustry			
215-0036 be filed within 72 ntal Hygiene. rked other than ' ent, the Medical	Completed	12th grade N/A Forklift Operator Med	nanic	Ruckert T	eminals			
e, MD 21215-C I and 2 should be filed the Health and Mental Hygi item 27 is marked oth	To Be C	17. Father's Nakyel(First, Middle, Last)  Leonard Inniss  Lynct	te. Fo	stmond				
21; nould be id Men is mar		19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and N mber or F	Rural Route Numb	er, City or Town, State	, Zip Code)			
e, MD and 2 sho feafth and item 27 is		Kenya Inniss / Wife 95 Ashbridge Dn  20a. Method of Disposition 20b. Place of Disposition (Name of certagery,		sex, MD	21221			
Ψ = # ; = <sub>1</sub>		1 Burial 2 Cremation 3 Removal from State crematory or other place)	,	20c. Location - City or				
Baltimor permit. Pages Department of Important: If		4 Donation 5 Other Specify: Arbutus Memorial 06 21. Signature of Funeral Service Licensee 22. Name and Address of Facility \ \( \alpha \)		Baltimor				
Balti permit. Departi Import		Daugher C. Ur 4905 York Road	Baltin	one MD 2	uncral Svos.			
Physician /Medical		23a. Part I. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease a. Chest injuries  Approximate InterBetween Onset as Death						
xaminer								
	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.							
	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause						
d sit	Examiner	events resulting in death) Last Due to (or as a consequence of):						
760, icate be executed physician and the burial - transit		d.						
60, ate be e hysicia e burial	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d Data of deliver				
5876 rtifica ling ph	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	ncy	23d. Date of delivery  Month	y Day <b>Ye</b> ar			
Box 687: death certific	Physician/	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown						
O.O. B that the de led by the detached i		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?			
, P.O. res that the signed by be detacled	d by		1 Yes	1 Yes 2 No 3 Probably 4 Unknown				
ords, w requir is been s should	Completed	(	24a. Was ar autopsy		topsy findings available ompletion of cause of			
Recc The lay cate ha	mo		perform 1 <b>V</b> Yes 2	ned? death?				
Vital Rec ysician: The I his certificate I	Be	25. Was case referred to medical examiner?	only one)					
f Vil Physic er this	흔	1 Ves 2 No Inpatient 2 ER/Outpatient 3 DOA Oute 4 Nursin		esidence 6 Other	:			
Division of Vital Records, rad or Attending Physician: The law requirers after death.  "I Director: After this certificate has been silted in by the funeral director, page 2 should be	Certification:	1 Natural 5 Pending Jun 23, 2007 0154 hrs 1 Yes 2 ✔ No		ator of motocycle	fixed object			
ivisior or Attend after death Director:	ifica	2 🗹 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (St		ral Route Number, City			
Dj spital hours a neral J	Cert	4 Homicide determined (Specify) Interstate/Express	I-83 at Chase S	or Town, State) at Chase Street Overpass, Baltimore, MD				
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	29a. Certifier (Check only one)  2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	Σ	29b. Signature and title of certifier  29c. License number		29d. Date signed (Moi	nth, Day, Year)			
		Carde Hallon O.C.M.E.		June 23, 2007 ———————				
7'		30. Name and address of person who completed cause of death (Item 23a)  Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201						
State 31. Date filed (Month Pay Yex) 2007 Registrar's Signature								

07-04719 Donal Lee Irvine

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		1- For State Critical Certificate of Death Registrar	_	. No.				
Physicia	an/	1. Decedent's Name (First, Middle,Last)	2. Date of Death		3. Time of Death			
Medical Exami	ner	Donal L. Irvine	June 20, 20	007	1704 hrs			
The same of the sa		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Carsins Run Rbad & Rt 22  Aberdeen		4c. County of Deat	h			
			In Data of Disti	Harford				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Age (In yrs. last birthday) If Under 2 Year If Und	_	(MM/DD/YYYY) 9. Bi Forei	nnplace (State or 9nWestVirgini ountry)			
		Usual Residence of Decedent						
an y	Funeral Director	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits			
Aaryland 28a-f show 1 at once.		Maryland Harford Joppa			1 Yes 2 X No			
Aaryla 28a-f		10e. Street and Number 10f. Zip Code	100	. Citizen of What Cou	intry?			
th the Maryland 23a or 28a-f sho notified at once.		2702 Green Spring Ave 21085		U.S.A.				
n with		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. 1. Never Married 2. V. Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame White, etc.	rican Indian, Black,			
r deat or ite must	핊	1 x Yes 2 No	raioun, oto.,	Whi	te			
s'afte	<u>Σ</u>	or Dates:			In dustria			
2 hours at "natural	ted	Elementary/Secondary (0-12) College (1-4 or 5+)		16b. Kind of Business	viridustry			
036 ithin 72 ne. r than "	Completed	2 Steel Worker	I = CI	Bethleher	ı Steel			
5-00 led wii tygier other ithe M	S	17. Father's Name (First, Middle, Last)  18. Mother's Name	(First, Middle, M	aiden Surname)	<del></del>			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medical	To Be	Levi Irvine Lula Bel	lle Mill	er				
ID 27 Should and Me 17 is ma		19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Fig. 19b. Mailing Address)		-	e, Zip Code)			
e, MD 2 1 and 2 shou Health and N item 27 is n		Edythe Irvine (Wife) 2702 Green Spring Ave		MD 21085 20c. Location - City of	r Tourn State			
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she rother traumatic event, the Medical Examiner must be notified at once		1 Burial 2 X Cremation 3 Removal from State crematory or other place)		ŕ				
Baltimore, permit. Pages I ar Department of Hee Important: If ite		Solidation of Total Speedy			, Maryland			
Baltimore permit. Pages I Department of H Important: If i		21. Signature of Funeral Service Treese 22. Name and Address of Facility Sch	nimunek E	Tuneral Hon	ne of Bel Air			
Physician	-	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or			Approximate Interval			
/Medical		failure. List only one cause on each line.  Between Onset and  Death						
Examiner		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):						
	. L	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):						
11 - =								
ecuted and transit	Medical Examin	d						
30, te be exe ysician a	ğ							
3760, ificate be ig physici s the buri	_	IF FEMALE: 23b. Was decedent pregnant in the 2ctopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnance	incv	23d. Date of delive Month	ry Day Year			
Box 687 The death certification is the attending part of the atten	sician	past 12 months?  Pregnant at time of death  Other (Specify)	oy	l monar				
Bo e deat the at	Phys	1 Yes 2 No 9 Unknown 9 Unknown						
P.O. es that the gened by be detach	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to				
ords, P.C. w requires that as been signed to should be deta	edt				obably 4 Unknown			
ord w req as bee	plet		24a. Was a	y prior to	utopsy findings available completion of cause of			
Rec The la	Completed		perform 1 <b>V</b> Yes 2		'es 2 No			
tal Rection: The certificate ector, page	Be C	25. Was case referred to medical examiner?	only one)					
Physic r this	2	1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Oute 4 Nursin		Residence 6 🗸 Oth	er: Scene			
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans		27. Manner of Death  28a. Date of Injury  1 Natural 5 Pending  28a. Date of Injury Jun 20, 2007  1655 hrs  1 Yes 2 ✓ No		ow injury occurred xed object collisi	on			
Sional Atternative deat	cati	2 ✓ Accident Investigation 28e Place of Injury - At home farm street, factory office building etc.	28f Location (St	reet and Number or F	tural Route Number, City			
Div ital or ital Div	Certification:	Suicide Could not be determined (Specify) Mains Dood ( Highway)	or Town, Sta					
Hospi 24 hou Funer tely fil		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
Division  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
F ≯ F 5	ME	29b. Signature and title of certifier 29c.License number		29d. Date signed (M	onth, Day, Year)			
		hy hu, nos		June 21, 2007				
12		30. Name and address of person who completed cause of death (Item 23a)						
Ling Li, wid Assistant Medical Examiner 111 Penn Street, Baltimore, Mid 21201								
St Regis		31. Date filed (Month, Day, Year)  32. Registrar's Signature						
		War I was a second and a second a second and a second and a second and a second and a second and		<u>-</u>				